OHIP

April 1, 1984

[redacted]

Schedule of Benefits

Physician Services

Ministry of Health
Ontario
Keith C. Norton, Minister

EXPLANATORY TO THOSE WHO USE THIS SCHEDULE OF BENEFITS

It may be of help to the person using this Schedule to digest this explanatory passage carefully. As may be seen in the following Table of Contents, there is a Preamble setting out general principles and definitions. The Preamble is followed by a listing of the consultation and visit fees and other items of a like nature for the use of Family Practice and Practice in General, followed by a similar listing for each of the recognized Specialty groups in alphabetical order. This is followed by separate Sections applicable to Laboratory Medicine, Nuclear Medicine, Radiation Oncology, Diagnostic Radiology, Clinical Procedures Associated With Diagnostic Radiological Examinations, Diagnostic Ultrasound, Pulmonary Function Studies, Diagnostic and Therapeutic Procedures and Obstetrics.

The next heading is "Surgical Procedures." The anatomical systems are listed in the Table of Contents; this is the key to the successful use of the publication. Under each system the procedures carried out within the system have been grouped under such sub-headings as Incision, Excision, Suture, Repair, etc. Thus each procedure listed may be located through determination of the anatomical system to which it applies, and the type of procedure. This method of listing has no relationship to the Specialty which may be engaged in surgery upon this particular system. On this matter, attention is called to the definition of a "Specialist" in the Preamble.

The fees listed under Diagnostic and Therapeutic Procedures may be charged in addition to the appropriate consultation or visit fees unless the procedure is the sole reason for the visit. In this latter circumstance, a basic fee per visit may be added to those procedures marked (+). The fees have not been listed particularly by anatomical system or specialty but rather in a manner which we believe will be most practical for those using the Schedule. Listings for biopsies, endoscopies, aspirations, etc., are set out in the surgical part of the Schedule as I.O.P. items.

The Laboratory Medicine part of the schedule is a relative value Fee Schedule which reflects the relative weighting of labour, material and supervision (L.M.S.) for each test. The relative value of each test is expressed in unit form; the fee for each test is determined by multiplying the unit value by the cent value stated in the Laboratory Medicine Preamble. When indicated, a patient documentation and specimen collection fee may be charged as well. The professional components for Anatomical Pathology, Histology and Cytology are expressed in dollar form and may be found at the end of the L.M.S. Schedule. Some of the common tests performed in physicians' offices are also listed under Diagnostic and Therapeutic Procedures; the L.M.S. fees for these particular tests apply to licensed laboratories only.

The basic values for anæsthetists and assistants at surgery are expressed in units rather than dollars. The total fees for these services are calculated by adding the basic and time units together and multiplying the sums by the appropriate dollar values stated on pages ix and x of the Preamble.

This Schedule lists the technical (T) and professional (P) components separately for many diagnostic procedures such as nuclear medicine examinations, pulmonary function tests, cardiography, etc. When a physician provides both the technical and professional components for a given test, the fee is billed as the sum of columns T plus P.

For most surgical procedures the major pre-operative visit i.e. consultation or appropriate assessment fee may be claimed in addition to the surgical fee; the exceptions to this rule are those few procedures marked Complete Care and Fractures and Dislocations requiring no reduction.

Certain surgical procedures have been listed as I.O.P. (Independent Operative Procedure). When a consultation or visit (assessment) plus an I.O.P. procedure are both rendered to the same patient, claims for each service rendered may be submitted.

The schedule contains a number opposite most listings for the benefit of those physicians who wish to report their services in coded form. The few items which are listed as N.A.B. represent services which are not insured benefits of OHIP; these services may be billed directly to patients.

In the surgical part of the Fee Schedule, physicians submitting claims in coded form should add to the code numbers, the suffix A if they perform the procedure, the suffix B if they have assisted at the surgery and the suffix C if they have administered the anæsthetic.

For those diagnostic and therapeutic procedures which have both technical and professional components listed, e.g., nuclear medicine, the suffix A should be added to the fee code when both components are being claimed, the suffix B when only the technical component is being claimed and the suffix C when only the professional component is being claimed.

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PREAMBLE

A. General

1. The rates listed in this Schedule of Benefits are the maximum payments which can be made by the Ontario Health Insurance Plan.

2. Insured medical services are limited to the services which are medically necessary, which are listed in this Schedule of Benefits and which are not specifically excluded by legislation or regulation (see Appendix A for a list of specific exclusions).

3. Additions, deletions or other modifications of the Schedule of Benefits require recommendation by the Ontario Health Insurance Plan. Such recommendations are made in consultation with the Ontario Medical Association.

4. This Schedule is a public document and frank discussion with patients regarding the listed rates is recommended.

5. Claims for services which are not listed in the Schedule or which are listed as N.A.B. (not a benefit) or which are excluded as benefits by legislation or regulation should not be submitted to the Plan. Such services may be charged directly to patients or others requesting them.

6. The principles governing proper professional charges are incorporated in the Regulations (Medicine) of the Health Disciplines Act.

7. Each physician who participates in the care of a patient is entitled to compensation commensurate with the services he renders.

8. Whenever possible, the physician should acquaint the patient or person financially responsible with his obligations to those concerned with his care. This is particularly important where supportive or concurrent care is rendered or when a consultation and/or procedure are being arranged.

9. Each physician participating in the care of a patient should render to the patient, or to the financially responsible party, an itemized statement of charges for professional services.

10. Each physician participating in the care of a patient should, on request, send a receipt to the patient for all payments made by him.

11. If fees are collected by an organized group, the name of the physician rendering the service should be clearly shown on the bill or claim card.

12. Claims may be submitted for services which a patient receives from the team of staff man, resident, intern and clerk in a teaching unit, provided that the conditions as set out hereunder apply.

On October 10, 1972, the Minister of Health confirmed that the joint recommendations of the College and the O.M.A. governing the charging of fees for services provided by interns and residents in clinical teaching units are acceptable to the Ministry of Health. In his letter the Minister made it very clear that he is looking to the College and the Medical Schools to ensure that the ethical rules governing these billing procedures are followed meticulously in all cases.

It has been carefully explained that the responsible staff man must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient at the earliest possible moment. No fees are to be charged for services given by the intern or resident prior to this identification taking place. The following rules are now in effect: –

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the physician responsible shall be personally identified to the patient. His relationship to the team shall be defined by the clinical teaching unit Director and his role must be known to the patient and other members of the team. He shall assume full responsibility for the appropriateness and the quality of the services rendered.

Specific regulations must vary with the service and form of care being delivered: –

(a) In order to claim for physical procedures being carried out by an intern or resident, the responsible staff man must be in the clinical teaching unit and immediately available to intervene.

(b) In psychotherapy where the presence of the staff man would distort the psychotherapy milieu, it is appropriate for the staff man to claim for psychotherapy when a record of the interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff man may not exceed the total time spent by him in both such interview and in direct supervision.

(c) In other departments or services, the staff man should only claim for visits on the days when actual supervision of that patient's care takes place through the presence of that staff man in the clinical teaching unit on that day. This, of course, involves a physical visit to the patient and/or a chart review with detailed discussion with the other member(s) of the health team.

(d) In those situations where on a regular basis a staff member might supervise concurrently multiple procedures or services through the use of other members of the team, the total claims made by the staff man shall not exceed the amount that the staff man might make in the absence of the other members of the team.

Any claim rendered should be in the name of the responsible staff man.

13. Charges for missed appointments are not benefits of OHIP.

PREAMBLE

B. Terms and Definitions:

Call or Visit: is the service by a physician to or on behalf of a patient for assessment and/or treatment.

1. Consultations:

(a) Consultation refers to the situation where a physician, in light of his professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field, because of the complexity, obscurity or seriousness of the case or because another opinion is requested by the patient or an authorized person acting on his behalf. The consultant is obliged to perform a general or specific assessment, review the laboratory or other data and submit his findings, opinions and recommendations in writing to the referring physician.

(b) If a consultant is requested by a physician on duty in the emergency department to see a patient in consultation, the former may charge a consultation fee for this service. If the consultant is requested to perform this same service by a resident or intern, the former may charge a general or specific assessment according to his specialty.

(c) **Consultations required by hospital by-law and/or statute are not insured service except where contrary indications are noted in this Schedule.**

(d) For laboratory and procedural charges connected with consultations, see listings of Diagnostic and Therapeutic Procedures and Laboratory Medicine.

(e) A consultation is not to be claimed as such when:

   (i) The patient presents himself to a consultant's office without prior knowledge of the primary physician. The sending of a report to the primary physician under these circumstances does not justify a consultation.

   (ii) The primary physician is not asked for professional advice but is simply asked by the patient for the name of a specialist in a particular field and the patient seeks out the specialist himself.

(f) A **repeat consultation** requires all of the criteria of a full consultation and implies interval care by the primary physician. The situation in which the consultant requests the patient to return for a later examination is not a repeat consultation.

(g) A **limited consultation** may involve all the components of a full consultation but is less demanding, and in terms of time, normally requires substantially less of the physician's time than the full consultation.

(h) A **diagnostic radiology consultation** applies when radiographs made elsewhere are referred to a radiologist for his written opinion or when a radiologist is required to make a special visit at Night (5:00 p.m. to 7:00 a.m.) or Saturdays, Sundays and Holidays to consult on the advisability of performing a diagnostic radiological procedure which eventually is not done. A consultation does not apply when the radiographs referred to above are used for comparison purposes with radiographs made in the consultant's facilities.

(i) A **diagnostic pathology consultation** applies when tissue, slides, and/or specimens are referred to a second pathologist **not in the same institution** for a written opinion. It includes secretarial or other assistance but does not apply when the above are used for comparison with tissue, slides, materials or tests done in the consultant's facilities. When a diagnostic pathology consultation fee is claimed, L821 may not also be claimed.

(j) A **pathology consultation or repeat consultation** applies when a pathologist is requested to examine a patient and provide a written opinion.

(k) A **diagnostic nuclear medicine consultation** applies when nuclear medicine studies are referred to a nuclear medicine specialist for a written opinion, or when the nuclear medicine physician is required to make a special visit at Night (5:00 p.m. to 7:00 a.m.) or Saturdays, Sundays and Holidays to consult on the advisability of performing a nuclear medicine procedure which eventually is not done. A consultation does not apply when procedures done elsewhere are used for comparison purposes with nuclear medicine studies made in the consultant's facilities.

(l) A **nuclear medicine consultation** or repeat consultation applies when a nuclear medicine specialist is requested to examine a patient and provide a written opinion, all of which takes a greater amount of time and effort than a nuclear medicine study would normally require. It may be done in conjunction with a nuclear medicine study but if so, the lesser professional fee (P_2) rather than the greater fee (P_1) should be claimed in addition to the technical fee (T).

(m) Some nuclear medicine specialists have other specialist qualifications which allow them to claim another consultation (e.g. internal medicine). A nuclear medicine consultation or repeat consultation may be claimed in lieu of another consultation (e.g. internal medicine) but would not be combined with such a consultation by the same consultant.

(n) A **prenatal consultation** by a paediatrician applies when a physician considers a foetus of greater than 20 weeks gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or foetal distress, and requests the opinion of a paediatrician competent to give advice in this field. The paediatrician shall perform a general or specific assessment, review laboratory and other data and submit his findings and recommendations in writing to the referring physician. Such a consultation does not preclude the paediatrician from a post-natal consultation on the infant.

(o) A special surgical consultation may apply when a surgeon provides all the components of a regular consultation but is required to spend considerably more time than usual in consultation because of the very complex, obscure or serious nature of the problem. The surgeon should claim for special consultations on an I.C. basis.

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Note: OHIP benefits for consultations normally are limited to one consultation per year, per patient, by any one physician. However, if the same patient is referred to the same consultant a second time within the year with a clearly defined unrelated diagnosis, one additional consultation may be claimed per year.

2. **General Assessment:** shall comprise a full history, an enquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient.*

   OHIP benefits for general assessments normally are limited to one per year per patient by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional general assessment may be claimed per year. In the case of a patient who proceeds normally to hospital, the admitting physician may claim one additional general assessment per year provided 90 days have elapsed since the last general assessment rendered (anywhere) to that patient by the admitting physician. If the patient doesn't qualify for a general assessment by the admitting physician, he may claim a general re-assessment.

3. **General Re-Assessment:** shall comprise the same services as a general assessment except that the history need not include all the detail already obtained in the original general assessment.*

   OHIP benefits for general re-assessments, except for hospital admission re-assessments, are limited to two per year, per patient, by any one physician.

4. **Specific Assessment:** shall comprise a full history of the presenting complaint, enquiry concerning, and detailed examination of the affected part, region or system, as needed to make a diagnosis, and/or exclude disease and/or assess function, an appropriate record, and advice to the patient.* (This may vary among sections.)

   Physicians qualified in two specialties (EENT for example) may only claim for one visit, e.g.: a consultation (if referred) or a specific assessment (if non-referred), if both systems are examined during the same visit. However, two consultations or two specific assessments, etc. may be claimed if both systems are examined, each on a separate visit.

   OHIP benefits for specific assessments normally are limited to one per year, per patient, by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional specific assessment may be claimed per year.

5. **Specific Re-Assessment:** shall comprise a full relevant history and a comprehensive physical examination of one or more systems but not requiring an evaluation of the patient as a whole.* This service is the admission assessment when the patient has been seen prior to admission in the same illness. It is included in the surgical fee except for those procedures marked I.O.P.

6. **Partial Assessment:** shall comprise a history of the presenting complaint, the necessary physical examination, an appropriate record and advice to the patient. It also applies to subsequent visits for assessing the response to treatment and/or advice provided in a previous service.

7. **Intermediate Assessment:** is a primary care service for physicians providing general practice or paediatric services and is a more extensive assessment than a minor assessment. It shall comprise a history of the presenting complaint(s), enquiry concerning and examination of the affected part(s), region(s) or system(s) or emotional disorder as needed to make a diagnosis, exclude disease and/or assess function, an appropriate record, and advice to the patient.*

8. **Multiple Systems Assessment:** shall comprise a detailed history and examination of more than one system, part or region, an appropriate record and advice to the patient.

9. **Minor Assessment:** is a brief assessment comprising the necessary history, examination of the affected part or region, an appropriate record and advice to the patient.

10. **Mini Assessment: applies when a physician examines and/or treats a patient for a completely unrelated problem in addition to the examination/treatment of a W.C.B. related problem (for which the W.C.B. will only pay a minor assessment) during the same office visit. The fee for the mini assessment is $4.00 (A008).**

11. **Re-Assessments (by physician on duty in the Emergency Department): one re-assessment may be charged when, at least two hours after the original assessment is completed (including appropriate investigation and necessary treatment), a subsequent assessment indicates that further provision of care and/or investigation is required and performed. Re-assessments are not to be claimed for discharge assessments nor when the patient is admitted by the physician on duty in the Emergency Department, nor when this assessment leads directly to referral for consultation.**

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12. **Well Baby Care:** the periodic visits of a well baby during the first two years of life involving complete examination with necessary weight and measurements and instructions to the parent(s) regarding health care.

13. **Annual Health or Annual Physical Examinations (Including Primary and Secondary School Examinations):** shall comprise all the elements of a general assessment as it pertains to an individual after the second birthday who presents and reveals no apparent physical or mental illness.

    OHIP benefits for any one physician are limited to one Annual Health Examination per patient per year after the second birthdate. To qualify, an Annual Health Examination normally must be requested by the patient rather than a third party. Regulation 452 of Revised Regulations of Ontario, 1980 under the Health Insurance Act, examinations for the purpose of "legal requirements or proceedings" are excluded from coverage. However, it is recognized that an Annual Health Examination will satisfy some or all of the requirements for examinations required by statute but excluded by the above mentioned Regulation. In such instances and where a prior claim for an Annual Health Examination has not been submitted to the Plan in the previous twelve months for that patient, it would be appropriate to submit a claim to OHIP for this service. The OHIP benefit in these cases covers the Annual Health Examination only and not any charges peculiar to the legal requirements, such as charges for the completion of forms.

14. **Long-Term Institutional Care** includes the listings for consultations, assessments and other visits to patients in chronic care hospitals, convalescent hospitals, nursing homes and other institutions in which such patients are covered by extended care legislation.
    Admission Assessments to Long Term Care Institutions:
    Type 1 – applies when the admitting physician has not performed a consultation, general assessment or general re-assessment prior to admission and when he carries out a general assessment (on admission) and provides a report for the medical record.
    Type 2 – applies when the admitting physician has performed and claimed for a consultation, general assessment or general re-assessment prior to admission, makes an initial visit and records an admission note describing the condition of the patient following admission.
    Type 3 – applies when the admitting physician readmits a patient after a 7 day stay in another institution; the admitting physician shall carry out a general re-assessment and provide a report for the medical record.

15. **Subsequent Visits to Long Term Care Institutions:** include the supervisory care as well as the active treatment of acute intercurrent illness when the physician is already in the long term care institution. The supervisory care component includes discussion with the patient **and/or family** and/or examination **of the patient** and also includes as required, discussion with the nurse, chart review and annotation of the chart. When acute intercurrent illness requires a special visit, the appropriate fees under General Listings and Premiums apply. **For acute illnesses requiring visits after the monthly maximums have been claimed, extra visits should be made on an I.C. basis (W121 – $8.60).**

16. **Pre-dental General Assessment:** is the history and examination of a patient required prior to dental surgery under anaesthesia in hospital. A **diagnosis is not required by OHIP for this service.**

17. **Newborn Care:** is the routine care of a well baby up to ten days of age and should include a complete physical examination of the baby and necessary instructions to the mother. The service shall involve at least two visits and normally may not be claimed for the same patient by more than one physician.

    When a well baby is transferred to another hospital (because of the mother's state of health, for example) claims for newborn care by a physician at each hospital may be appropriate.

18. **Low Birth Weight Baby Care:** is the care of a baby weighing less than 2.5 kilograms at birth.

19. **Psychotherapy:** is any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying, or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development. Accordingly, therefore, a psychotherapeutic procedure may be claimed if a half hour or major part thereof has been spent by a physician in such treatment of the patient. The minimum time period for psychotherapy (to be charged as such) is twenty minutes. In order to claim for a major portion of a second or subsequent time interval of psychotherapy for the same patient during the same visit, the preceding time interval must be a full 30 minutes of psychotherapy. When psychotherapy extends beyond thirty minutes, the major part (16 minutes) of the next half hour must be spent with the patient to qualify for an additional half hour fee. Similarly, after one hour of psychotherapy, the major part (16 minutes) of the next half hour, must be spent to qualify for an additional half hour, and so on.

20. **Counselling:** as distinct from psychotherapy, counselling is that form of activity in which the physician engages in an educational dialogue with the patient(s), on an individual or group basis wherein the goal of

the physician and patient(s) is to become aware of the patients' problems or situation and of modalities for prevention and/or treatment. **Counselling is not to be claimed for the advice that is a normal part of any consultation or assessment, for ongoing treatment or as a substitute for patient assessment fees. Counselling must be rendered personally by the attending physician.**

21. **Genetic Counselling:** includes interviewing the appropriate family members, the collection and assessment of adequate clinical and genetic data to make a diagnosis, construct a pedigree, and assess the risks to persons seeking advice. It includes imparting this information and the various alternatives to the appropriate family members for dealing with the problem in such a way that they can make informed decisions about the genetic problem.

22. **Documentation:** when a physician examines or treats a patient, an appropriate record of such service should be made. See Appendix B.

23. **Visit for Procedure:** when the sole reason for an office visit is the performance of a certain procedure, the listed benefit for the procedure will apply. (See Diagnostic and Therapeutic Procedures Preamble for exceptions.) When procedures are carried out in the office, emergency or outpatient department on an elective basis, special visit fees should not be claimed in addition to the procedural fee. When procedure(s) are carried out by a physician's employee(s) under the direct supervision of the physician, the usual claims may be made for procedure(s) which are generally and historically accepted as those which may be carried out by the nurse or other medical assistant in the employ of the physician. "Procedures" in this context do not include such services as assessments, consultations, pyschotherapy, counselling, etc. Direct supervision requires that during the procedure the physician be physically present in the office or clinic at which the service is rendered.** While this does not preclude the physician from being otherwise occupied he should be in personal attendance on enough occasions to ensure that procedures are being performed competently and he must at all times be available immediately to approve, modify or otherwise intervene in a procedure as required in the best interests of the patient.

    For physiotherapy procedures performed under direct physician's supervision as detailed above, see Code G467 on Page 52.

24. **Health Examination:** this may vary in extent according to the purpose for which required (e.g. pre-employment, insurance, free from infection, etc.). **This is not a benefit of OHIP and** the fee should be according to the type of assessment necessary for this purpose and billed to the patient or party requesting the service.

25. **Age:** (unless otherwise specified)
    Newborn–up to 10 days of age.
    Infant–up to 2 years.
    Child–up to and including 15 years.
    Adolescent–up to and including 17 years.
    Adult–18 years or over.

26. **Most Responsible Physician:** is the attending physician who is primarily responsible for the day to day care of the patient in hospital. In cases of unusual severity where the consultant assumes the role of the most responsible physician, the consultant may claim on a per visit basis and the family physician may claim supportive care. Where the family physician remains the most responsible physician and requests only a consultation, the family physician may claim on a per visit basis and the consultant may claim a consultation only.

27. **Transferral and Referral:**
    (a) A **referral** takes place when one physician requests for his patient the services of another. The services of the latter may consist of:
        (i) an opinion (i.e. a consultation).
        (ii) diagnostic tests or procedures (e.g. skin test, biopsy, etc.).
        Note: In such cases the referring physician continues to treat the case himself.
        (iii) treatment (surgical or medical).
        The referring physician's OHIP registration number must be included on the claim submission.
    (b) A **transferral,** as distinguished from a referral, takes place where the responsibility for the care of the patient is completely transferred permanently or temporarily, from one physician to another (e.g. where the first physician is leaving temporarily on holidays and unable to continue to treat the case). Physicians who are substituting for other physicians should consider that patients of the latter have been temporarily transferred (not referred) to their care. The physician to whom the patient is transferred should be regarded as substituting for the other physician. Where the care of the patient

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*For laboratory and other investigation performed in conjunction with a consultation or visit, see Diagnostic and Therapeutic Procedures and Laboratory Medicine.

involves a benefit containing several components such as surgery, the physicians may consider the surgical benefit a team benefit and decide among themselves how each is to be compensated; traditionally physicians in these circumstances have reciprocated by exchanges of coverage for each other. When physicians routinely or frequently substitute for each other in providing hospital visits to registered bed patients in active treatment hospitals e.g. weekend coverage or daily rounds by various members of a group, the most responsible physician may claim for all the visits.

28. **Concurrent Care:** applies when the family physician remains the most responsible physician but because of the seriousness or complexity of the condition, requests continued directive care by a consultant. The family physician may claim on a per visit basis and the consultant may also claim on a per visit basis not to exceed four such claims during the first week of concurrent care and not to exceed two such claims each week thereafter while the patient's condition remains serious–this arrangement being agreeable to both physicians.

29. **Multidisciplinary Care:** applies when the complexity of the medical condition requires the services of several physicians in different disciplines. In such cases, each physician should render a separate account on a per visit basis. This does not refer to a situation where a single benefit for a team of physicians is listed in the schedule.

30. **Supportive Care:** is the care rendered in hospital by the referring physician, who is not actively treating the case (e.g. writing orders), to a patient under the care of another physician, at the desire of the patient or family, for purposes of liaison or reassurance. The physician should be remunerated for this care on a per visit basis not to exceed four such claims during the first week of supportive care (determined by the date of the first supportive care visit) and not to exceed two such claims each week thereafter. If medical complications develop or are present in the post-operative period which require active management by the referring physician, hospital medical care fees should be applied not supportive post-operative fees.

31. **Terminal Care (In Hospital):** applies to one designated physician responsible for the care of a terminally ill patient. Terminal care will be deemed to start when there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs. Terminal care should be claimed for retroactively after death on the basis of visits actually rendered for a period not to exceed four weeks prior to death. Terminal care visit fees as described above do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

32. **Independent Consideration–"I.C.":** Independent consideration may be given in exceptional circumstances and where a set fee is not listed in the Fee Schedule. Claims rendered under this heading should contain an explanation of the fee claimed. It is helpful if claims for I.C. include an operative or consultation report and a comparison of the scope and difficulty of the procedure with other procedures in the Schedule.

33. **Specialist:** A specialist shall be defined (for purposes of application in the case of any given service within this Schedule) as one who holds a certificate from The Royal College of Physicians and Surgeons of Canada in the specialty which normally is considered to encompass the service in question.

A specialist rendering services outside of his specialty should use the codes and tariffs listed in the General Practice section of the Schedule.

34. **Differential Benefits:**
    - (a) Where only one procedural fee is listed, it shall apply to any physician rendering the service, regardless of specialty.
    - (b) Specialists providing primary care in general practice may claim the appropriate visit fees (as defined in the Preamble) listed under the heading Family Practice and Practice in General. Certain other non specialist services such as counselling and interviews are under the same heading for the use of any physician providing such services.
    - (c) Specialists in pædiatrics who practice allergy may claim specialist fees for their allergy services regardless of the age of their patients.

35. **Referring Physician's Services:**
    - (a) For the services rendered prior to the operation, the referring physician should claim on a fee-for-service basis, for example:
        - (i) Visits as rendered.
        - (ii) In addition to (i) above, in acute cases if detained, he may claim detention fees if appropriate. See para. 44) p. xiv.
    - (b) (i) For services rendered as an assistant during the operation, the referring physician should claim an assistant's fee.

(ii) In cases in which the referring physician is required to be present in the interest of the patient but does not actually assist at the surgical procedure, he should claim on a hospital visit basis for this service.

(c) For the services rendered after the operation, the referring physician may claim on the basis of supportive care fees as outlined in the schedule.

36. **Assistants' Services:**

(a) The assistants' fees are determined by adding the listed basic units and time units and multiplying the total number of units by **$7.50.** For all cases commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the total assistant's fee by 30%. (E400B). For all cases commencing after midnight and before 7:00 a.m. any night of the week, increase the total assistant's fee by 50% (E401E).

(b) When a physician is required to make a special visit to the hospital to assist at surgery, he may charge a special visit premium of **$15.00** (C998B) for a case commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, or **$30.00** (C999B) for a case commencing after midnight and before 7:00 a.m. any night of the week. These premiums are in addition to the E400 and E401 premiums but apply only to the first patient treated on each special visit.

(c) The time units are computed by allowing one unit **($7.50)** for each 15 minutes or part thereof of time (up to two hours) spent by the assistant. When assisting for more than two hours per case, time units for periods in excess of two hours are computed by allowing two units for each 15 minutes or part thereof. Time for purposes of these calculations includes scrub time and time spent in the operating room. If billings are being made in coded form (see explanatory comments at front of Fee Schedule), the suffix B should be added to the fee code for the procedure. The basic units should be listed separately from the time units on the claim card.

(d) When multiple or bilateral surgical procedures are done during the same anæsthetic, the assistant's benefit shall be based on the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anæsthetics, the assistant shall be entitled to receive a full assistant's benefit for each procedure.

(e) In surgical procedures requiring more than one assistant, the second assistant shall compute his fee on the same basis as the first assistant. Each claim for second assistant should be accompanied by a statement from the operating surgeon confirming the necessity for his/her services.

(f) When a surgeon requires an assistant at a procedure for which no assistant's fee is listed, the assistant may calculate his fee by taking the number of basic units used by the anæsthetist, adding his time units and multiplying the total number of units by **$7.50.**

(g) When assistants at surgery bill for procedures for which no assistants' fees have actually been listed in the schedule, the assistants should support their claims with a statement of explanation from the surgeon, confirming the medical necessity for their attendance.
Note: Code M400B to be used by OHIP for services performed by an assistant where no assistant units are listed. All such services must be assessed for appropriateness by the OHIP Medical Consultant.

(h) Where the attendance of a physician is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and when the physician is in constant attendance, the fee shall be 3 units plus time (E003B).

(i) When an anæsthetic has begun and the operation is cancelled prior to commencement of surgery, the assistant who has scrubbed but is not required to do more, should claim 3 basic units plus time units. (E006B). If the operation is cancelled after surgery has commenced, the procedural basic units plus time units will apply. If the procedure is cancelled prior to the induction of anæsthesia and the assistant is scrubbed, a subsequent hospital visit only may be claimed.

37. **Anæsthetists' Services:**

(a) The tariff is for all types of anæsthesia. The fee is for professional services, including pre-anæsthetic evaluation and post-anæsthetic follow-up and all immediate supportive measures, and does not include the cost of materials used.

(b) **If an anæsthetist is requested by another physician to see a patient in consultation (see para. 1(a)) because of the complexity, obscurity or seriousness of the case prior to the administration of an anæsthetic, he may claim a consultation fee as well as the anæsthetic fee. If this consultation is provided less than 36 hours prior to the administration of an anæsthetic, this consultation should be claimed at $50.60 under fee code E015. The routine pre-anæsthetic evaluation of the patient required by the Public Hospitals Act does not qualify as a consultation, regardless of where and when this evaluation is performed. Anæsthetic consultations do not apply when hospital, departmental by-laws, statutes or policies require automatic consultations on any patient requiring anæsthesia.**

(c) If an anæsthetist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anæsthesia, he or she may claim a subsequent hospital visit fee for this service. When an anæsthetic

*For laboratory and other investigation performed in conjunction with a consultation or visit, see Diagnostic and Therapeutic Procedures and Laboratory Medicine.

has begun and the operation is cancelled due to a complication prior to the commencement of surgery, the anæsthetist should claim 4 basic units plus time (E006C). If the operation is cancelled after surgery has commenced, the procedural basic fee plus time units will apply.

(d) The anæsthetist's fees are determined by adding the basic and time units together and multiplying the sum by **$8.62** for certified anæsthetists and **$7.95** for non-certified anæsthetists. For cases commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the total anæsthetic fee by 30% (E400C). For cases commencing after midnight and before 7:00 a.m., any night of the week, increase the total anæsthetic fee by 50% (E401C).

(e) When an anæsthetist is required to make a special visit to the hospital to administer an anæsthetic, he may claim a special visit premium of **$15.00** (C998C) for a case commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays or **$30.00** (C999C) for a case commencing after midnight and before 7:00 a.m. any night of the week. These premiums are in addition to the E400 and E401 premiums but only apply to the first patient treated on each special visit.

(f) Basic units are listed for most procedures and include the value of all anæsthetic services except the actual time spent administering the anæsthesia, any modifying factors, or unusual detention with the patient (see paragraph n).

(g) Except during maintenance of continuous conduction anæsthesia time units are computed by allowing one unit for each 15 minutes or part thereof of anæsthesia time (up to two hours); following the first two hours of anæsthesia, time units for periods in excess of two hours shall be computed on the basis of two units for each 15 minutes or part thereof. Anæsthesia time begins when the anæsthetist is first in attendance with the patient for the purposes of creating the anæsthetic state and ends when he is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

(h) If claims are being made in coded form (see explanatory comments at front of Fee Schedule), the suffix C should be added to the fee code for the procedure.

(i) **In special cases when the anæsthetic services of more than one anæsthetist are deemed necessary in the interest of the patient, the second anæsthetist shall charge 4 basic units (E001) plus time units for the time spent assisting the first anæsthetist.**

(j) When multiple or bilateral surgical procedures are done during the same anæsthetic, the anæsthetic benefit shall be based upon the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anæsthetics, the anæsthetist shall be entitled to receive a full anæsthetic fee for each procedure.

(k) In procedures where no value is listed, or with I.C., the basic portion of the calculated value will be the same as listed for a comparable procedure considering region and modifying conditions or techniques.

(l) When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anæsthetic, the anæsthetic "Basic Units" will be 28 units; this replaces the listed basic units for the procedure. To compensate for variations in anæsthetic practice, special respiratory intensive care or detention for the purpose of intensive treatment of other types should be claimed for separately under the appropriate headings.

(m) Controlled hypotension may be billed for (10 units) when it is carried out in association with anæsthesia using any technique to deliberately lower and maintain the mean blood pressure **by** at least 25%. **Incidental hypotension from the use of any anæsthetic agent does not constitute controlled hypotension.** The additional 10 units may be claimed under E004C.

(n) When unusual detention with the patient before or after anæsthesia is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated for the anæsthetic time.

(o) For detention not associated with anæsthesia detention rates and criteria (see paragraph 42 on page xiii).

(p) When the attendance of the anæsthetist is requested by the patient's other medical attendants for the purpose of monitoring or special supportive care, and when the anæsthetist is in constant attendance, the benefit shall be 3 units plus time. The code is E003C.

(q) **Introduction of a catheter for continuous conduction analgesia and anæsthesia in obstetrics has a basic value of 6 units. Maintenance and/or supervision may be claimed at one unit for each half hour of maintenance to a maximum of 5 units. No fee is chargeable for the first hour following introduction of the catheter and first dose. Time units for delivery may be claimed at one unit per quarter hour.**

(r) When a physician administers an anæsthetic and/or other medication prior to or during a procedure(s) and also performs a procedure(s) on the same patient, he should claim for the procedure(s) only. However, when a physician administers a pudendal, femoral, intercostal, sciatic, ilioinguinal, iliohypogastric, **ulnar, median or radial** block in addition to performing a procedure, he may claim **$11.25** (G224) in addition to the procedure.

(s) When hypothermia is used by the anæsthetist in procedures not specifically identified as requiring hypothermia, the basic value is 25 units. This basic value replaces the basic value listed in the Schedule for the procedure. When the basic value claimed is 25 units, the anæsthetic service may be claimed under code E002C.

(t) **When a patient is known to have malignant hyperthermia or there is a strong suspicion of susceptibility, and the anæsthetic requires full malignant hyperthermia set up and management, add 2 units to the anæsthetic claim (E012).**

(u) **Anæsthetic management for the emergency relief of acute upper airway (above the carina) obstruction (excluding choanal atresia) – basic 10 units (E013).**

(v) When one anæsthetist starts a procedure and is replaced by another part way through a surgical procedure or delivery, the first anæsthetist should charge the appropriate basic fee plus time units and the second anæsthetist should charge for time units only. The second anæsthetist should use code E005C for such time units except in the case of continuous conduction anæsthesia; **for which P015 (plus E100C) applies** (see para. 37(q)). E002C, E003C, E004C, E005C qualify for the premiums E400C or E401C only if the case originally started within the time stated under para. 35(d) above.

Each anæsthetist should state on his/her claim card which part of the anæsthetic is being claimed and the time begun and completed.

(w) General anæsthesia for the purposes of this Fee Schedule includes all forms of anæsthesia except local infiltration.

(x) Maintenance/Supervision of epidural catheter for relief of pain (G247) see p. 49. For visits rendered after 5 p.m. and after midnight or on Saturdays, Sundays and Holidays add 30% (E402). For visits after midnight but before 7 a.m. add 50% (E403).

38. **General Listings:** include the basic listings for consultations, assessments and other visits wherever they are rendered, except for non-emergency services to hospital or long-term care institution in-patients and for care rendered by a physician on duty in the emergency department. These latter services are listed separately in the Schedule.

39. **Non-Emergency Hospital in-Patient Services:** include the fee listings for consultations and other visits rendered to registered bed patients on a non-emergency basis.

(a) When a patient has not been seen previously by the physician in charge, the first visit after admission may be claimed as a consultation or general or specific assessment. When the patient has been previously attended before admission, the first visit after admission may be claimed as a general re-assessment or specific re-assessment (depending on the specialty) if the patient has been seen before in the same illness. However when a patient is admitted to hospital by one physician and is subsequently transferred to another physician, only one general or specific assessment or re-assessment may be claimed per patient admission.

(b) Subsequent routine visits should be claimed as subsequent visits (minor assessments). Payments for hospital visits are usually limited to one per patient per day prior to the weekly and monthly limitations that apply after the patient has been hospitalized for 5 weeks, (6 weeks for pædiatricians). However, it is not the intent of the Fee Schedule that visit fees be claimed for every day a patient is in hospital unless a physician actually visits the patient each day. For acute illnesses or exacerbation of original illness requiring hospital visits after 5 weeks of hospitalization, claims for extra visits should be made on an independent consideration basis.

(c) When a patient in hospital is referred by one physician to another, the second physician should not be limited by the "Subsequent Hospital Visit" formula for the number of hospital visits already rendered by the first physician. In other words, the second physician is entitled to claim for his visits up to 5 weeks just as if the patient was being attended to in hospital for the first time. If the patient is transferred to the care of another physician, the "Subsequent Hospital Visit" formula would apply just as it would if only one physician was involved in the care.

(d) When a physician is already in the hospital and is asked to assess one of his own in-patients on a non emergency or emergency basis, the subsequent hospital visit listings apply. However if he is asked to assess another physician's patient on an emergency basis, the General Listings apply.

40. **Emergency Department – Physician on Duty Services:** include the fee listings for minor and multiple systems assessments **and re-assessments** and the specific premiums applicable to the services rendered by the physician on duty. Any physician on duty in the emergency department should claim these fees regardless of his specialty.

The listings under the heading "Emergency Department – Physician on Duty" are meant to apply to those circumstances wherein either emergency or other physicians have elected or are required to be physically and continuously present in the Emergency Department or environs for an arranged designated period of time. **These listings also apply to services rendered to patients who arrive in the Emergency Department after a physician on call has made a special visit and examined and/or treated the waiting patient(s) who were responsible for the special visit.** When an emergency physician is required to make a special visit to the Emergency Department prior to or after his regular arranged designated period of time on duty, he may charge the appropriate fee under the General Listings plus the applicable special visit premium for the first patient assessed; all subsequent patients assessed during this visit to the hospital should be billed under the Emergency Department – Physician on Duty listings.

When a physician is on duty in the Emergency Department, sees a patient and admits the patient to hospital, this physician may claim a minor or multiple systems assessment depending on the service initially provided. Either the patient's attending physician or the emergency department physician (but not both) may render and claim the hospital admission assessment. If the emergency department physician (instead of the attending physician) provides the admission general assessment, he may claim a general re-assessment (C004) as well as the initial assessment provided both services are actually rendered separately.

41. **Long-Term Institutional Care:** See paragraph B.14.

Premiums:

42. **Special Visit Fees Applicable in Addition to Fees For Services Listed Under Consultations and Visits, Critical Care and Injections or Infusions (pages 1-14, 44, 47).**

(a) A special visit is one initiated by a patient or his representative which requires a physician to travel from one location to another to see a patient(s). The appropriate special visit applies when a physician makes a special visit to his office (outside normal office hours) even if his office is in his home, when he makes a special visit to the Emergency Department, O.P.D., hospital, long-term care institution, the patient's home or other location (hotel, roadside, ski slope etc.).

(b) A special visit may also involve an emergency call with sacrifice of office hours. The benefits for this type of special visit apply in a situation where the demands of the patient and/or the physician's interpretation of the patient's condition is such that the physician responds immediately and makes a special visit at the sacrifice of regular office hours.

(c) A special visit at night or on a Saturday, Sunday or holiday may be claimed when non-elective or emergent calls are made by the physician between 5:00 p.m. and 7:00 a.m. or are received and made on Saturdays, Sundays and Holidays. Holidays are defined for the purpose of this Schedule as New Year's Day, Good Friday, Easter Monday, Victoria Day, **Canada** Day, Civic Holiday, Labour Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. If any of these holidays fall on a Saturday or Sunday, the Friday before or Monday following will be recognized as the holiday.

(d) Only one special visit (daytime; emergency call with sacrifice of office hours; or nights, Saturdays, Sundays and Holidays) may be claimed for the same patient, same visit. Special visits only apply to non-elective or emergent calls and do not apply to non referred or transferred obstetrics. Special visits do not apply to visits on regular rounds nor do they apply to admission assessments of patients who have been admitted to hospital on an elective basis, regardless of the time performed.

(e) An elective home visit is a visit to a patient's home deemed medically necessary by the physician, initiated by the physician or the patient and carried out at any time convenient to the physician. Physicians providing such services should charge in addition to the appropriate fee under the heading General Listings, the premiums under paragraph **42**(i) only, even if the elective visits are rendered at Night, on Saturdays, Sundays and Holidays.

If an institution has arranged to have quarters in the same or in a proximal building in order that a physician will be available to make visits to the institution, particularly at night, these are not considered to be "special visits" to the institution.

If a physician is called to pronounce a patient dead, a minor assessment may be claimed along with the appropriate surcharge for the special visit.

(f) When additional patients are assessed during special visits, the "additional patient" premiums are not normally applicable unless the additional patient himself qualifies for a special visit. However, extra patients **seen** during a home visit while the physician is there rendering a special visit to another patient also qualify for the "additional patient" premiums if an assessment is rendered. Patients who drop in to the office while the physician is there for reasons other than rendering a special visit do not qualify for any of the special visit premiums. Extra in-patients seen during a special visit to a hospital or other institution do not qualify for the "additional patient" premiums unless the physician has been asked specifically to see these extra patients as well. Patients seen during "office hours" held at night or on Saturdays, Sundays or holidays do no qualify for any of the special visit premiums.

(g) When no consultation or visits may be claimed e.g. for post-op hospital visits by operating surgeon, the minimum premiums for special visits apply for additional patients seen during a special visit. Minimum premiums also apply to additional patients seen requiring Critical Care (excluding Respiratory Care and Neonatal Intensive Care), Injections or Infusions.

(h) **K992, C992, K993, C993** are also applicable to assistant and/or anæsthetist at non-elective surgery.

(i) **Daytime Special Visits (Monday to Friday) to Emergency Department or O.P.D.:** for other locations see below.

K990	First patient seen	add	$12.40
K991	For each additional patient requiring a special visit and seen during same special visit, add 20% to consultation or visit – minimum		5.80

(j) **Emergency Call with Sacrifice of Office hours:**

K992	First patient seen	add	$24.75
K993	For each additional patient requiring a special visit and seen during same special visit, add 20% to consultation or visit fee – minimum		7.70

(k) **Evenings (5:00 p.m. to midnight) and Saturdays, Sundays, Holidays:**

K994	First patient seen	add	24.75
K995	For each additional patient requiring a special visit and seen during same special visit, add 20% to consultation or visit – minimum		7.70

(l) **Nights (midnight to 7:00 a.m.):**

K996 First patient seen .... add 37.10

For each additional patient requiring a special visit and seen during same special

K997 visit, add 50% to consultation or visit – minimum 11.60

(m) **Special Visit to the Patient's Home or Equivalent:** use the appropriate listing above (h, i, j or k) but substitute the prefix **"B"** for "K" (e.g. B990 instead of K990).

(n) **Special Visit to Hospital In-Patient:** use the appropriate listing above (h, i, j or k) but substitute the prefix **"C"** for "K" (e.g. C990 instead of K990).

(o) **Special Visit to Long-Term Care Institution:** use the appropriate listing above (h, i, j or k) but substitute the prefix **"W"** for "K" (e.g. W990 instead of K990).

(p) **Special Visit to Office:** use the appropriate listing above (h, i, j or k) but substitute the prefix **"A"** for "K" (e.g. A990 instead of K990).

(q) **Special Visit to Any Setting Not Listed Above, or Emergency Service at Roadside, Ski-slope etc.:** use the appropriate listing above (h, i, j or k) but substitute the prefix **"Q"** for "K" (e.g. Q990 instead of K990).

43. **Special Care Unit (e.g. I.C.U. or C.C.U.):**
For each patient seen on visit to I.C.U. or C.C.U. (excluding supportive care, respiratory care and neonatal intensive care)
C101, add to all such hospital visits 6.20

44. **Detention:** may be charged when a physician is required to spend considerable extra time in active treatment of the patient (and to the exclusion of all other work) Claims for detention must be substantiated by an explanation on the claim card or in an accompanying letter, and should be made on an "I.C." basis according to the following guidelines:

After 20 minutes if the physician spends more than this amount of time providing a minor, partial or intermediate assessment or subsequent hospital visit;

After 40 minutes if the physician spends more than this amount of time providing a specific or general re-assessment;

After 1 hour if the physician spends more than this amount of time providing a consultation, repeat consultation, specific or general assessment.

Detention is not meant to apply to procedural items or obstetrics and does not include time waiting for x-rays, lab reports or for the operating room.
K001 – Per quarter hour or part thereof 15.00

45. **Detention: While in Attendance With Patient(s) in Ambulance:**
K101 – Per quarter hour or part thereof 26.25

Note: K101 is not applicable to attendance in a vehicle other than an Ambulance.

46. **Non Elective Surgical Procedures, Obstetrics or Clinical Procedures Associated With Diagnostic Radiological Examination or Detention While in Attendance With Patient(s) in Ambulance:** – when such procedures including fractures or dislocations or major invasive procedures contained in the list of Diagnostic and Therapeutic Procedures or elective procedures which because of intervening emergency procedure(s) commence after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the procedural fee(s) by 20% (E409). When the foregoing procedures commence after midnight and before 7:00 a.m. any night during the week, increase the procedural fee(s) by 50% (E410).

These premiums are not chargeable in addition to the obstetrical fee(s) if labour is induced by medical and/or surgical means by the same physician **unless the reason for the induction is fetal distress, diabetes, severe pre-eclampsia – hypertension or abruption.** However a forewater A.R.M or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

Major Invasive Procedures are considered to be the following:

G211
G246
G254
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G412
G418
R833
R840
R841
R843
R849
R850
R851
R852
R853
R854
Z804
Z805

These premiums are not chargeable (during or after a "shift") by emergency or other physicians who have elected or are required to be physically and continuously present in the Emergency Department or environs for an arranged designated period of time.

E409 or E410 may not be claimed for procedures which mainly involve the interpretation of test results and are not applicable to assessments or consultations. Neither are they applicable to procedures listed in the Diagnostic Radiology, Nuclear Medicine or Diagnostic Ultrasound sections of the Schedule.

47. **Non Elective Diagnostic Radiology, Laboratory Medicine, Nuclear Medicine or Diagnostic Ultrasound Examinations:** – when a physician providing the foregoing services makes a special visit to see a patient in consultation, perform a procedure or conclude that a procedure is not medically indicated, between 5:00

p.m. to midnight or on Saturdays, Sundays and Holidays, a **$24.75** premium (C109) should be claimed in addition to the appropriate consultation fee or procedural fee or by itself if the decision is made not to perform the procedure. For such services rendered between midnight and 7:00 a.m., the premium is **$37.10** (C110).

48. **Anæsthetists' Services:** – for all cases commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the total anæsthetic fee by 30%. (E400C) For all cases commencing after midnight and before 7:00 a m., any night during the week, increase the total anæsthetic fee by 50% (E401C).

For cases requiring a special visit to the hospital, an additional premium of **$15.00** (C998C) during the 30% premium period and **$30.00** (C999C) during the 50% premium period may be charged to the first patient treated on each special visit.

49. **Assistants' Services:** – for all cases commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the total assistant's fee by 30% (E400B). For all cases commencing after midnight and before 7:00 a.m., any night during the week, increase the total assistant's fee by 50% (E401B).

For cases requiring a special visit to the hospital, an additional premium of **$15.00** (C998B) during the 30% premium period and **$30.00** (C999B) during the 50% premium period may be charged to the first patient treated on each special visit.

50. **Travelling Time:** may be charged directly to patients (since it is a non-insured service) when special visits are made by physicians to see patients outside their normal area of practice. Travelling time may be charged at the same rate as detention.

51. **A Locum Tenens**
    (a) Must replace the employing physician, who must be absent from the practice.
    (b) Must replace the employing physician for a continuous period up to a maximum of 12 weeks, with an extension on request for a further 6 weeks.
    (c) Must be the same specialty as the employing physician.
    (d) Must be licensed by the College of Physicians and Surgeons of Ontario in a category of licence that allows him or her to practice independently without supervision.

Prior notification must be given OHIP of the name and OHIP physician number and/or licence number of the locum tenens and the exact dates of employment, together with an authorization from the locum tenens to make payment for his or her services to the employer.

If these conditions are met, the locum tenens may sign the employing physician's claim cards.

If any of the above conditions are **not** met, the physician involved must submit claims to OHIP on his or her own claim cards.

PREAMBLE

APPENDIX A

Sections 53 and 54 of Ontario Regulations 452 of Revised Regulations of Ontario 1980 made under the Health Insurance Act.

"(1) The following services are not insured services under the Plan:

- Except where medically required, surgery for cosmetic purposes.
- Expenses for travelling time or mileage.
- Testimony in a court, preparation of records, reports, certificates or communications.
- Advice by telephone.
- Any service or examination for the purpose of,
  - (a) an application for insurance or under a requirement for keeping insurance in force:
  - (b) an application for admission to or continuance at or in a school, college, university, camp, association, club, group or program:
  - (c) employment or the continuance of employment or pursuant to the request of an employer or other person in authority:
- Group examinations, immunizations or inoculations.
- Any service or examination rendered by a physician for screening, survey or research purposes.
- Services rendered by a physician pursuant to an arrangement for rendering services.
  - (a) to the employees of an employer;
  - (b) to members of an association; or
  - (c) at a camp to the campers thereof.
- Laboratory services except,
  - (a) laboratory services prescribed in section 48a, and
  - (b) laboratory services carried out by a physician for the exclusive purpose of diagnosing or treating his own patients in the course of his medical practice.
- Special appliances.
- Clinical pathology, except when authorized by a physician and performed.
  - (a) by a laboratory mentioned in clause 52 (1)(a) or (b); or
  - (b) by or under the direction of any other person authorized by law.
- All procedures of acupuncture.

(2) The following services rendered by physicians shall be deemed not to be insured services for the purposes of the Act:

- Anaesthetic services rendered in connection with a dental procedure rendered by a dentist except where the dental procedure is performed in a hospital.
- Pre-adoption examination and evaluation for C.A.S.
- Other scan (approved but not currently listed).
- Preparation of special antigens or anti-serums.
- Special investigations.
- Dermatoglyphics.
- Group psychotherapy – seventh to ninth hour per day.
- Psychotherapy – interviews with other paramedical organizations or others on behalf of a patient.
- Orthoptics.
- Contact lens fitting, except for any of the following conditions:
  - (a) Aphakia, monocular and binocular;
  - (b) High Myopia, greater than nine diopters;
  - (c) Irregular astigmatism (post-corneal grafting or corneal scarring resulting from disease states);
  - (d) Keratoconus.
- Non-referred mammography or thermography.
- The use of EDTA in the treatment of atherosclerosis.
- HCG treatment for obesity.
- General assessment for nicotine addiction or obesity where treatment is to be by acupuncture or ear pins.

54. The following service rendered by a physician shall be deemed not to be an insured service in respect of an insured person who is eighteen years of age or over:

1. Otoplasty for correction of "outstanding ears".

55(1) The following services rendered outside of Ontario by physicians shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years:

1. Ligation, cauterization or removal of vas deferens–uni or bilateral (vasectomy).
2. Hysterectomy or ligation, cauterization or removal of fallopian tubes–uni or bilateral by abdominal or vaginal approach, including laparoscopy, culdoscopy, or hysteroscopy–for sterilization (any method).

55(2) All services rendered outside of Ontario by hospitals in connection with the services specified in subsection 1 shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years.

55(3) Subsections 1 and 2 do not apply where the surgeon or the attending physician believes that the surgical operation is medically necessary for the protection of the physical health of the insured person.

55a(2)-1. Any service or examination for the purpose of legal requirements or proceedings, other than an examination rendered by a psychiatrist, who is not a member of the medical staff of a psychiatric facility in which a patient is detained, for the purpose of clause 35(4)(*b*) of the *Mental Health Act*.

PREAMBLE

APPENDIX B

Section 29 of Regulation 448 of Revised Regulations of Ontario, 1980 under the Health Disciplines Act.

29–(1) A member shall,

- (a) keep a legibly written record in respect of each patient of the member setting out,
  - (i) the name and address of the patient,
  - (ii) each date that the member sees the patient.
  - (iii) a history of the patient,
  - (iv) Particulars of each physical examination of the patient by the member,
  - (v) investigations ordered by the member and the resultsof the investigations,
  - (vi) each diagnosis made by the member respecting the patient, and
  - (vii) each treatment prescribed by the member for the patient;
- (b) keep a day book, daily diary or appointment record setting out the name of each patient seen or treated or in respect of whom a professional service is rendered by the member.

(2) A member shall keep the records required under subsection (1) in a systematic manner and shall retain each record for a period of six years after the date of the last entry in the record or until the member ceases to engage in the practice of medicine, whichever first occurs.

(3) A member shall make records kept pursuant to subsection 1 and books, records, documents and things relevant thereto available at reasonable hours for inspection by a person appointed by the Registrar pursuant to section 64 of the Act, a member appointed by the Registrar for the purpose of peer review or a person appointed as an inspector under section 43(1) of the Health Insurance Act.

PREAMBLE

APPENDIX D

1. Surgery to alleviate significant physical symptoms that are refractory to medical treatment that has been actively undertaken for at least a six month period, or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is a benefit under the Ontario Health Insurance Plan. Surgery solely to alter or restore appearance is not a benefit of OHIP except under the circumstances as listed in the following policy.
2. Emotional, psychological or psychiatric grounds are not considered sufficient reason for OHIP coverage of surgery for alteration of appearance except under exceptional circumstances.
3. On request of the attending physician, exceptions may be made on an independent consideration basis if the proposed surgery is to alter a significant defect in appearance caused by disease, trauma or congenital deformity, and if the surgery is
    - recommended by a Mental Health Facility (as designated by The Mental Hospitals Act) or equivalent, or
    - performed on a patient who is less than 18 years of age and the defect is in the area of the body which normally and usually would not be clothed, or
    - recommended by a Correctional Institution (tattoo removal only), or
    - essential in order to obtain employment as documented by the attending physician and either by a Canada Manpower Employment Centre or by an employer with regard to a specific job, (tattoo removal only).
4. In establishing this policy, it has been recognized that
    - peer acceptance in our society often is influenced disproportionately by the facies,
    - children are especially susceptible to emotional trauma caused by physical appearances.
5. Surgery to revise or remove features of physical appearance which are familial in nature is not a benefit of OHIP.
6. Within the context of this policy, the word "disease" does not include the normal sequelae of aging. Surgery to alter changes in appearances caused by aging is not a benefit of OHIP.
7. Within the context of this policy, the word "trauma" includes trauma due to treatment such as surgery, radiation, etc.
8. The phrase "reasonable period of convalescence" should be considered as two years. Independent consideration will be given to the questionable cases.
9. Authorization from OHIP is not required for all surgery to alter appearance. It is required only for those categories of procedures for which some cases may not be a benefit under OHIP policy.
10. Suitable documentation may be requested by OHIP in some cases before authorization can be considered.
11. The treatment of acute medical or surgical complications resulting from surgery for alteration of appearance and/or function is a benefit of the Plan whether or not the original surgery was covered by OHIP. No authorization is required.
12. Revision of surgery for alteration of appearance, because of undesirable results, is a benefit of the Plan if the original surgery was a benefit and if the revision either is part of a pre-planned staged process or occurs within a reasonable period of convalescence. OHIP authorization is required only if the original surgical procedure, if it had been carried out at the time of the proposed revision, would have required such authorization.

Surface Pathology

1. **Trauma Scars**
    (a) Neck or Face
    - Includes ears and non-hair bearing areas of the scalp.
    - Repair of all such scars is a benefit of OHIP, except for scars resulting from previous surgery to alter appearance that was not originally a benefit of OHIP.
    - Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures for cosmetic reasons, however, are not a benefit of OHIP.
    - OHIP authorization for repair of such scars is not required but manual assessment of the claims will be necessary to ensure that the most appropriate procedure codes are used.

    (b) Scars in other Anatomical Areas
    - Repair of scars which interfere with function or which are significantly symptomatic (pain, ulceration, etc.) is a benefit of OHIP.
    - Scars with no significant symptoms or functional interference
        (i) Repair is a benefit if such a repair is part of a pre-planned post-traumatic (including post-surgical) staged process. OHIP notification must be included as part of the planning process.
        (ii) Other post-traumatic scar revision is not a benefit of OHIP.
    - OHIP authorization is required for all scar repair procedures in areas other than the face or neck. Scar revision codes should be used (R026-R029).
2. **Keloids**
    (a) Head or Neck
    - The repair of all such keloids is a benefit of OHIP.

    - Repair procedures may include excision, injection, dermabrasion or planing.
    - No OHIP authorization is required.
  - (b) Excision of keloids in other areas
    - Not a benefit of OHIP unless significantly symptomatic (pain, ulceration, etc.) or there is functional impairment.
    - OHIP authorization is required.

3. **Tattoos**
   - (a) Face or Neck
     - Excision or destruction of all such tattoos is a benefit of OHIP.
     - Authorization is not required for adjudication of repair procedures will be identical to that for scars in these areas.
   - (b) Other Anatomical Areas
     - Excision or destruction of concentration camp or P.O.W. tattoos is a benefit of OHIP. Otherwise, not a benefit of OHIP except as described in Para D-3 (Page xix).
4. **Benign lesions such as naevi, keratoses, spider naevi, papillomata, neurofibromata**
   - (a) Face or Neck
     - Excision or destruction of these lesions is a benefit of OHIP.
     - Authorization is not required.
   - (b) Other anatomical Areas
     - Normally not a benefit of OHIP if removed for alteration of appearance only, rather than for medical necessity or because of clinical suspicion or evidence of malignancy.
     - Removal of very large lesions in patients less than 18 years of age is a benefit of OHIP.
     - Authorization is not required but **a statement of the reason for removal must accompany the claim.**
5. **Hair Loss**
   - (a) Head or Neck
     - (i) Patients less than 18 years of age
       - Repair is a benefit for non-heriditary etiologies.
       - Authorization is not required. However, if it is possible that a planned staged procedure will extend beyond the age limit, pre-authorization should be obtained, since it will be necessary after the 18th birthday.
     - (ii) Post-traumatic
       - Repair to the area of traumatic hair loss is a benefit of OHIP only if carried out within a reasonable period of convalescence. (See Para 7, page xix).
       - OHIP authorization is required.
       - Usual repair procedures may include skin shifts of flaps, skin grafts, or hair plugs.
     - (iii) Other Etiology
       - Not a benefit of OHIP.
   - (b) Other Anatomical Areas
     - Not a benefit of OHIP.
6. **Epilation of Hair**
   - (a) Face
     - This procedure is a benefit of OHIP only for those patients with documented endocrine abnormality or drug-induced hirsutism.
   - (b) OHIP authorization is required.
   - (c) Other Anatomical Areas – Not a benefit of OHIP.
7. **Redundant Skin**
   - (a) Excision of redundant skin for elimination of wrinkles, etc. is not a benefit of OHIP.
   - (b) Blepharoplasty is not a benefit of OHIP unless there is documented evidence of medical necessity from the appropriate physician such as visual field defect caused by the redundant eyelid skin.
     OHIP authorization is required. (Include documentation of visual fields).

Sub-Surface Pathology

1. **Congenital deformities**
   - (a) Head or Neck
     - Repair is a benefit of OHIP except for:
     - surgery to revise or remove features which are familial in nature or do not interfere with function
     - surgery to correct "outstanding ears" in patients who are eighteen years of age or over.
     - OHIP authorization is required.
   - (b) Other Anatomical Areas
     - Normally not a benefit of OHIP if surgery is for alteration of appearance only.
2. **Post-Traumatic Deformities**
   - Reconstructive procedures are a benefit at the acute stage; within two years, or if part of a pre-planned staged process of repair.
   - Repair of procedures may include bone revision, tissue shifts and grafts, prosthesis implantation, etc.
   - OHIP authorization is required for repairs beyond the acute stage.

3. Deformities resulting from local disease (such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.)

(a) Head or Neck

- Reconstructive procedure for significant abnormalities are a benefit at the acute stage; during a chronic disease process; within a reasonable period of convalescence (see Para 7, Page xix) or if part of a planned staged process of repair initiated during one of these periods.
- Repair procedures normally could include tissue grafts, flaps or shifts, bone revision, prosthesis insertion, etc.
- Face lifts, modified face lifts, brow lifts, etc., are not a benefit of the Plan if skin only is involved in the procedure. However, a repair such as ptosis repair or face lift with underlying slings is a benefit of OHIP if the procedure is to correct significant deformity following stroke, cancer, VIIIth nerve palsy, etc.
- OHIP authorization is required for repair of deformities resulting from local disease.

(b) Other Anatomical Areas

- Not a benefit of OHIP if the correction is for appearance only.

4. Breast Surgery

(a) Augmentation Mammoplasty

- This procedure is a benefit of OHIP unilaterally or bilaterally for a female patient with breast aplasia.
- It may be an OHIP benefit unilaterally for a female patient with a severely hypoplastic breast. Additional documentation may be required.
- The correct code for the repair procedure is R112.
- OHIP authorization is required.

(b) Post-Mastectomy Reconstruction

- Unilateral or bilateral breast reconstruction is a benefit of OHIP when the procedure is subsequent to total or partial mastectomy (including wedge resection) or prophylactic mastectomy as listed in the Schedule of Benefits.
- Authorization is not required.

(c) Reduction Mammoplasty

- Reduction Mammoplasty may be approved where there is significant associated symptomatology. Ptosis and/or size are not sufficient grounds for OHIP coverage of reduction mammoplasty.
- Unilateral Reduction Mammoplasty may be a benefit of the Plan if there is gross disproportion present or in association with approved unilateral augmentation mammoplasty, or post mastectomy reconstruction of the contralateral breast. Additional documentation may be required.
- OHIP authorization is required.

(d) Mastectomy

- This procedure is a benefit of the Plan.
- Authorization is not required.

(e) Accessory Breasts or accessory nipples

- Excision of such accessory tissue is a benefit of the Plan.
- The appropriate code should be used from the Schedule listings under Skin and Subcutaneous tissue.
- Authorization is not required.

5. Septorhinoplasty

- This is a benefit of OHIP when the rhinoplasty component is necessary to obtain an adequate airway or following trauma within 2 years or part of a pre-planned staged plastic repair. (See Para 7, Page xix).
- In cases where a septoplasty is necessary to improve function and a rhinoplasty is done to improve the cosmetic effect, OHIP will pay the part of the operation that was medically necessary (e.g. if a septorhinoplasty is performed and a septoplasty was necessary to improve the airway, OHIP will pay M012 and the surgeon is entitled to claim the difference from the patient.)
- OHIP authorization is required. A description of the external deformity should be provided.

6. Excision of excess fatty tissue and/or skin is not a benefit of the Plan except for panniculectomy where there is significant symptomatology.

- OHIP authorization is required.

7. Sex-Reassignment Surgery

(1) Sex-reassignment surgical procedures are a benefit of OHIP only if they are performed on patients who have completed the Gender Identity Clinic program operated by the Clarke Institute of Psychiatry in Toronto. Moreover, claims are accepted for payment only for those patients for whom the Clinic has recommended that surgery take place. This surgery need not take place in Toronto or even in Ontario. Surgery recommended by the Clinic which takes place outside the Province of Ontario may be approved for payment at rates in accordance with the current OHIP Schedule of Benefits.

(2) Within the foregoing guidelines, reconstruction of genitalia and mastectomy are benefits of the Plan. However, since the hormonal treatments associated with sex-reassignment themselves give rise to breast enlargement, augmentation mammoplasty or breast reconstruction in a male to female conversion is not a benefit of OHIP, in keeping with the previously outlined policy regarding breast surgery in females.
OHIP authorization is required.

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL (00)		
	General Listings:		
A005	Consultation		$40.10
A006	Repeat consultation		30.50
A003	General assessment		37.10
A004	General re-assessment		21.60
A903	Pre-dental general assessment		32.40
A007	Intermediate assessment/well baby care		17.40
A001	Minor assessment		12.75
K017	Annual health examination–child after second birthday		22.50
K009	–adolescent, adult		32.40
A009	Oculo-visual assessment (**i.e. major eye examination to include refraction and tonometry**)		30.00
N.C.	Telephone advice including renewal of prescriptions		N.A.B.
N.C.	Dispensing service fee		N.A.B.
	Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable)		
C005	Consultation		40.10
C006	Repeat consultation		30.50
C003	General assessment		37.10
C004	General re-assessment		21.60
C903	Pre-dental general assessment		32.40
	Subsequent visits: (minor assessments)		
C002	up to five weeks	per visit	11.80
C007	from sixth to thirteenth week inclusive (not to exceed $35.40 per week)	per visit	11.80
C009	after thirteenth week (not to exceed $70.80 per month)	per visit	11.80
C008	Concurrent care (minor assessment)	per visit	11.80
C010	Supportive care: (minor assessments)		9.75
H007	Attendance at maternal delivery for care of a high risk baby–(if only service rendered at time of delivery)		46.50
H001	Newborn care in hospital and/or home		39.75
H002	Low birth weight baby care (uncomplicated) initial visit (per baby)		24.75
H003	thereafter	per visit	12.75
	Emergency Department–Physician on Duty: (see para. B40 of Preamble)		
H103	Multiple systems assessment–includes interpretation of x-ray, E.C.G. and other laboratory data as required		20.25
H101	Minor assessment		10.30
H104	**Re-assessment (see Preamble – para. B11)**		**10.10**
	When above visits are rendered by the physician on duty in premium hours, apply one of the following premiums to H101, H103 or H104 rendered during the patient visit.		
H110	–12 midnight to 8:00 a.m.–50%		
H106	–Saturdays, Sundays or Holidays–20%		
	When any other service is rendered by the physician on duty in premium hours (and H101, H103 are not chargeable), apply one of the following premiums per patient visit.		
H112	–12 midnight to 8:00 a.m.		10.10
H113	–Saturdays, Sundays or Holidays		4.05
	Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in Emergency or O.P.D.: use General Listings		
	Long Term Institutional Care: (for emergency calls and other special visits to institutional patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).		
	Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, or Other Institutions in Which Patients are Covered by Extended Care Legislation:		
W105	Consultation		40.10
W106	Repeat consultation		30.50
W102	Admission assessment (see Preamble) Type 1		37.10
W104	Type 2		12.75
W107	**Type 3**		**21.60**
W109	Annual physical examination		32.40
W004	General re-assessment of patient in nursing home and covered by extended care legislation (as per the Nursing Homes Act)		12.75
W903	Pre-dental and pre-surgery general assessment		32.40
	Subsequent visits (minor assessments see para. B15):		

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL	
	–chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W002	–first two visits per month (chargeable by most responsible physician) ... per visit	$11.80
W001	–subsequent visits per month ... per visit	8.10
	–nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W003	–first visit per month (chargeable by most responsible physician) ... per visit	11.80
W008	–subsequent visits per month ... per visit	8.10
	Homes for the Aged and Other Institutions in Which Patients are Not Covered by Extended Care Legislation: (use General Listings and Premiums [para. B42 of Preamble] when applicable.) General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.	
	Psychotherapy: (includes narcoanalysis or psychoanalysis or treatment of sexual dysfunction)	
K007	Individual–per ½ hour or major part thereof (see Preamble) ...	34.80
	Group–(four to eight people) per ½ hour or major part thereof	
K012	–per member (up to six hours per day) ...	6.45
N.C.	–per member (seventh to ninth hour per day) ...	N.A.B.
K004	Family–(two or more family members in attendance at the same time) per ½ hour or major part thereof ...	39.40
	Hypnotherapy:	
K006	Individual–per ½ hour or major part thereof ...	34.80
K011	Group, for induction and training for hypnosis (up to eight people) per ½ hour or major part thereof, per member ...	6.45
K013	**Counselling**–intended as an educational experience–not intended for ongoing therapy or as a substitute for a minor assessment–one or more people–per ½ hour or major part thereof ...	33.20
	Note: Psychotherapy or hypnotherapy or counselling are not to be charged in conjunction with other consultations or visits rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services.	
	Certification of Mental Illness–	
K623	Application for psychiatric assessment, (as mandated by the Mental Health Act) – including necessary history, examination, **notification of the patient, family and relevant authorities** and completion of form ...	63.75
K624	Certification, of involuntary admission (as required by the Mental Health Act) – including history, examination, **notification of the patient, family and relevant authorities** and completion of form ...	75.00
K629	All other re-certification(s) of involuntary admission ...	22.50
N.C.	Certification of incompetence (financial) including assessment to determine incompetence ..	N.A.B.
	Interviews	
K002	Interviews with relatives on behalf of a patient, per ½ hour or major part thereof ...	33.20
K003	Interviews with C.A.S. or legal guardian on behalf of a patient, per ½ hour or major part thereof ...	33.20
	Diagnostic interview and/or counselling with child and/or parent:	
K008	for psychological problem or learning disabilities, per ½ hour ...	34.80
N.C.	for testing per ½ hour ...	N.A.B.
N.C.	Interviews with other paramedical organization or others on behalf of a patient, per ½ hour or major part thereof ...	N.A.B.
N.C.	Case conference–with medical and/or paramedical personnel on behalf of a patient–per ½ hour or major part thereof ...	N.A.B.
	Genetic Counselling:	
K019	Individual or family–per ½ hour (maximum 2 hours) ...	39.40
K020	Interview with relatives–per ½ hour (maximum 2 hours) ...	39.40
	Note: The minimum time period required for any of the time based services listed on this page is twenty minutes–see para. 19 of Preamble for elaboration of the principles of the billing procedure.	
	Sexual Assault Examination for Investigation and/or Confirmation of Alleged Sexual Assault and Documentation	
K018	–female ...	190.00
K021	–male ...	150.00

Premiums for Special Visits by Physicians, Detention Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see Para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL–Cont'd.	
	Certification and Reports: **With or Without Examination:**	
N.C.	Certification of health (ordinary) or competency	N.A.B.
N.C.	Free from infection (barbers, waiters, etc.)	N.A.B.
N.C.	Certification of disability or previous immunization, Insurance report based on previous examination or on illness or death	N.A.B.
N.C.	Medico-legal report or reports required by law or hospital by-laws (e.g. therapeutic abortion committee) – the fee should reflect fairly the difficulty of the matter, the experience and expertise of the physician, the nature and complexity of the report and the time required to prepare it	N.A.B.

ALLERGY (39)

Since the Royal College of Physicians and Surgeons of Canada has not set a standard for "Allergy Specialist", fees for consultations and visits shall be applicable to a specific allergist as they refer to him in his own General or Specialty Tariff except for the following:

K399	Clinical interpretation by immunologists where a report of a survey is submitted in writing to the patient's physician (not to apply when the immunologist receives a consultation fee)	$20.60

ANAESTHESIA (01)

General Listings:

A015	Consultation	58.10
A016	Repeat consultation	37.10
A013	Specific assessment	33.40
A014	Partial assessment	15.00

Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C015	Consultation		58.10
C016	Repeat consultation		37.10
C013	Specific assessment		33.40
C014	Specific re-assessment		19.50
	Subsequent visits: (minor assessments)		
C012	up to five weeks	per visit	13.10
C017	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C019	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C018	Concurrent care (See Preamble)	per visit	13.10

CARDIOLOGY, CLINICAL IMMUNOLOGY, GASTROENTEROLOGY, HEMATOLOGY, RESPIRATORY DISEASE AND RHEUMATOLOGY

Specialists in the above specialities should bill for their services according to the consultation and visit fee schedule on pages 14 to 14c.

CARDIOVASCULAR AND THORACIC SURGERY (09)

General Listings:

A095	Consultation	42.40
A096	Repeat consultation	32.25
A093	Specific assessment	29.25
A094	Partial assessment	15.00

Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Premiums for Special Visits by Physicians, Detention Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see Para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code **CARDIOVASCULAR AND THORACIC SURGERY**–Cont'd.

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Code	Service		Fee
C095	Consultation		$42.40
C096	Repeat consultation		32.25
C093	Specific assessment		29.25
C094	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C092	up to five weeks	per visit	13.10
C097	from sixth to thirteenth weeks inclusive (not to exceed $39.30 per week)	per visit	13.10
C099	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C098	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care – Chronic and Convalescent Hospital, Homes for the Aged – Patients Covered by Extended Care Legislation and Nursing Homes

Code	Service	Fee
W095	Consultation	42.40
W096	Repeat consultation	32.25

DERMATOLOGY (02)

General Listings:

Code	Service	Fee
A025	Consultation	39.00
A026	Repeat consultation	31.90
A023	Specific assessment	28.50
A024	Partial assessment	14.70

Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Code	Service		Fee
C025	Consultation		39.00
C026	Repeat consultation		31.90
C023	Specific assessment		28.50
C024	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C022	up to five weeks	per visit	13.10
C027	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C029	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C028	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes.

Code	Service	Fee
W025	Consultation	39.00
W026	Repeat consultation	31.90

GENERAL SURGERY (03)

General Listings:

Code	Service	Fee
A035	Consultation	42.40
A036	Repeat consultation	32.25
A033	Specific assessment	29.25
A034	Partial assessment	15.00

Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see Para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	GENERAL SURGERY–Cont'd.		
C035	Consultation		$42.40
C036	Repeat consultation		32.25
C033	Specific assessment		29.25
C034	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C032	up to five weeks	per visit	13.10
C037	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C039	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C038	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes

W035	Consultation	42.40
W036	Repeat consultation	32.25

Code	INTERNAL MEDICINE (13)	

General Listings:

A135	Consultation	82.50
A435	Limited consultation	54.00
A136	Repeat consultation	54.00
A133	General assessment	43.50
A134	General re-assessment	31.50
A138	Partial assessment	18.00

Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C135	Consultation		82.50
C435	Limited consultation		54.00
C136	Repeat consultation		54.00
C133	General assessment		43.50
C134	General re-assessment		31.50
	Subsequent visits: (minor assessments)		
C132	up to five weeks	per visit	13.10
C137	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C139	after thirteenth week (not to exceed $ 78.60 per month)	per visit	13.10
C138	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care: (for emergency calls and other special visits to institutional patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes or other Institutions in which patients are Covered by Extended Care Legislation:

W235	Consultation		82.50
W435	Limited consultation		54.00
W236	Repeat consultation		54.00
W232	Admission assessment (see Preamble) Type 1		37.10
W234	Type 2		12.75
W237	**Type 3**		**21.60**
W239	Annual physical examination		32.40
	Subsequent visits (minor assessments):		
	–chronic care or convalescent hospital (maximum of 10 per patient, per month)		
W132	–first two visits per month (chargeable by most responsible physician)	per visit	13.10
W131	–subsequent visits per month	per visit	9.90
	–nursing home or other institution, covered by extended care legislation (maximum of 5 per patient, per month)		

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	INTERNAL MEDICINE–Cont'd.		
W133	–first visit per month (chargeable by most responsible physician)	per visit	$13.10
W138	–subsequent visits per month	per visit	9.90

Homes for the Aged and Other Institutions in which Patients are Not Covered by Extended Care Legislation: use General Listings and Premiums (para. B42 of Preamble) when applicable. General Listings under these circumstances also apply to patients seen in bed rather than an office supplied by the institution.

LABORATORY MEDICINE (28) – the following fees are applicable to specialists in Medical Biochemistry, Medical Microbiology, Anatomic and General Pathology

General Listings:

A285	Consultation		54.00
A286	Repeat or limited consultation		37.10
A585	Diagnostic consultation – see definition in Preamble		20.60

Non-Emergency Hospital In-Patient Services: (see para B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C285	Consultation		54.00
C286	Repeat or limited consultation		37.10
C585	Diagnostic consultation		20.60
C288	Concurrent care	per visit	13.10

NEUROLOGY (18)

General Listings:

A185	Consultation		82.50
A385	Limited consultation		54.00
A186	Repeat consultation		54.00
A183	General assessment		43.50
A184	General re-assessment		31.50
A188	Partial assessment		18.00

Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C185	Consultation		82.50
C385	Limited consultation		54.00
C186	Repeat consultation		54.00
C183	General assessment		43.50
C184	General re-assessment		31.50
	Subsequent visits: (minor assessments)		
C182	up to five weeks	per visit	13.10
C187	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C189	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C188	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes:

W185	Consultation		82.50
W385	Limited consultation		54.00
W186	Repeat consultation		54.00

NEUROSURGERY (04)

General Listings:

A045	Consultation		63.00
A046	Repeat consultation		35.60

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code

NEUROSURGERY–Cont'd.

Code			
A043	Specific assessment		$35.60
A044	Partial assessment		18.00

Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:– use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C045	Consultation		63.00

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

C046	Repeat consultation		35.60
C043	Specific assessment		35.60
C044	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C042	up to five weeks	per visit	13.10
C047	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C049	after thirteenth week (not to exceed $ 78.60 per month)	per visit	13.10
C048	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes:

W045	Consultation	63.00
W046	Repeat consultation	35.60

NUCLEAR MEDICINE (63)

G635	Consultation	46.50
G634	Repeat consultation	33.00
G935	Diagnostic consultation–see definition in Preamble	20.60
G632	Partial assessment	18.00

OBSTETRICS AND GYNAECOLOGY (20)

General Listings:

A205	Consultation*	41.60
A206	Repeat consultation*	32.25
A203	Specific assessment*	29.25
A204	Partial assessment*	15.00

Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings.

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C205	Consultation*		41.60
C206	Repeat consultation*		32.25
C203	Specific assessment*		29.25
C204	Specific re-assessment*		18.00
	Subsequent visits: (minor assessments)		
C202	up to five weeks	per visit	13.10
C207	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C209	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C208	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospitals, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes:

W305	Consultation*	41.60
W306	Repeat consultation*	32.25

*May include biopsy of cervix, (**except when done in conjunction with A204**), Papanicolau smear, examination of trichomonas suspension.

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – See para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

OPHTHALMOLOGY (23)

General Listings:

A235	Consultation		$40.50
A236	Repeat consultation		32.25
A233	Specific assessment		30.00
A234	Partial assessment		15.00

Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C235	Consultation		40.50
C236	Repeat consultation		32.25
C233	Specific assessment		29.25
C234	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C232	up to five weeks	per visit	13.10
C237	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C239	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C238	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes:

W535	Consultation		40.50
W536	Repeat consultation		32.25

ORTHOPAEDIC SURGERY (06)

General Listings:

A065	Consultation		39.00
A066	Repeat consultation		31.90
A063	Specific assessment		28.50
A064	Partial assessment		15.00

Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C065	Consultation		39.00
C066	Repeat consultation		31.90
C063	Specific assessment		28.50
C064	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C062	up to five weeks	per visit	13.10
C067	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C069	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C068	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for the Aged–Patients Covered by Extended Care Legislation and Nursing Homes:

W065	Consultation		39.00
W066	Repeat consultation		31.90
	Subsequent visits (minor assessments)		
	–chronic care or convalescent hospital (maximum of 10 per patient, per month)		
W062	–first two visits per month (chargeable by most responsible physician)	per visit	11.60
W061	–subsequent visits per month	per visit	9.90
	–nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)		
W063	–first visit per month (chargeable by most responsible physician)	per visit	11.60
W068	–subsequent visits per month	per visit	9.90

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	OTOLARYNGOLOGY (24)		
	General Listings:		
A245	Consultation		$ 40.50
A246	Repeat consultation		32.25
A243	Specific assessment		29.25
A244	Partial assessment		15.00
	Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings		
	Non-Emergency Hospital In-patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).		
C245	Consultation		40.50
C246	Repeat consultation		32.25
C243	Specific assessment		29.25
C244	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C242	up to five weeks	per visit	13.10
C247	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C249	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C248	Concurrent care (minor assessments)	per visit	13.10
	Long Term Institutional Care–Chronic and Convalescent Hospital, Homes for Aged–Patients Covered by Extended Care Legislation and Nursing Homes:		
W345	Consultation		40.50
W346	Repeat consultation		32.25
	PAEDIATRICS (26)		
	General Listings:		
A265	Consultation		82.50
A665	Prenatal consultation		50.25
A565	Limited consultation		54.00
A266	Repeat consultation		54.00
A263	General assessment		39.00
A264	General re-assessment		25.90
A007	Intermediate assessment/well baby care		17.40
A261	Minor assessment		12.75
K267	Annual health examination–child after second birthday		22.50
K269	–adolescent		32.40
	Diagnostic interview and/or counselling with child and/or parent–see Practice in General Listings (p. 2)		
	Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings		
	Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).		
C265	Consultation		82.50
C665	Prenatal consultation		50.25
C565	Limited consultation		54.00
C266	Repeat consultation		54.00
C263	General assessment		39.00
C264	General re-assessment		25.90
	Subsequent visits: (minor assessments)		
C262	up to six weeks	per visit	13.10
C267	from seventh to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C269	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C268	Concurrent care (minor assessments)	per visit	13.10
H267	Attendance at maternal delivery		46.50

Premiums for Special Visits by Physicians, Dentention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	**PAEDIATRICS**—Con'td.		
H261	Newborn care in hospital and/or home		$42.40
	Low birthweight baby care (uncomplicated)		
H262	—initial visit (per baby)		37.10
H263	—thereafter	per visit	12.75
N.C.	**Pre-adoption examination and evaluation for C.A.S.**		N.A.B.
	Chronic and Convalescent Hospital:		
W265	Consultation		82.50
W565	Limited consultation		54.00
W266	Repeat consultation		54.00
W562	Admission assessment (see Preamble) Type 1		37.10
W564	Type 2		12.75
W567	**Type 3**		**21.60**
	Subsequent visits (maximum of 10 per patient, per month)		
W262	—first two visits per month (chargeable by most responsible physician)	per visit	13.10
W261	—subsequent visits per month	per visit	9.10
W269	Annual physical examination		22.50

Note: In surgical cases requiring medical direction, standard in hospital medical fees are to be charged in addition to the surgical fee. This includes all operations on babies under one year of age, and all other older children who require medical supervision.

PHYSICAL MEDICINE AND REHABILITATION (31)

General Listings:

A315	Consultation		82.50
A515	Limited consultation		54.00
A316	Repeat consultation		54.00
A313	General assessment		43.50
A310	General re-assessment		31.50
A314	Partial assessment		18.00

Emergency or O.P.D.—Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: — use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble — for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C315	Consultation		82.50
C515	Limited consultation		54.00
C316	Repeat consultation		54.00
C313	General assessment		43.50
C314	General re-assessment		31.50
	Subsequent visits: (minor assessments)		
C312	up to five weeks	per visit	13.10
C317	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C319	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C318	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care:

Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes or Other Institutions in which Patients are Covered by Extended Care Legislation:

W515	Consultation		82.50
W310	Limited consultation		54.00
W516	Repeat consultation		54.00
W512	Admission assessment (see Preamble) Type 1		37.10
W514	Type 2		12.75
W517	**Type 3**		**21.60**
W419	Annual physical examination		32.40
	Subsequent visits (minor assessments):		
	—chronic care or convalescent hospital (maximum of 10 per patient, per month)		
W312	—first two visits per month (chargeable by most responsible physician)	per visit	13.10

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees — see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	PHYSICAL MEDICINE AND REHABILITATION–Cont'd.		
W311	–subsequent visits per month	per visit	$ 9.90
	–nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)		
W313	–first visit per month (chargeable by most responsible physician)	per visit	13.10
W318	–subsequent visits per month	per visit	9.90

Homes for the Aged and Other Institutions in which Patients are Not Covered by Extended Care Legislation: – use General Listings and Premiums (para. B42 of Preamble when applicable). General Listings under these circumstances also apply to patients seen in bed rather than an office supplied by the institution.

Team Management in a Rehabilitation Unit (active in-patient rehabilitation management from the initiation of rehabilitation care).

Active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to fee codes H312, H317 and H319 means when this service is rendered by one physiatrist even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit, the weekly and monthly limitations under the following fee codes apply to the total rehabilitation care rendered. In other words, it is not possible to charge the maximum fees allowed under C312, C317 and C319 and then start billing de novo under H312, H317 and H319 under the above circumstances.

H312	up to twelve weeks	per visit	13.10
H317	from thirteenth to twenty-sixth week (not to exceed $39.30 per week)	per visit	13.10
H319	twenty-sixth week onwards (not to exceed $78.60 per month)	per visit	13.10

	Rehabilitation Procedures: Interviewing and counselling of patients and/or relatives	
H313	per half hour or major part thereof (includes report)	33.20
K313	**Physiatric Management:** applies to physiatrists regulating the day to day management of patients **when medical necessity requires** prescription development, advice and supervision. It may be billed on the days when rehabilitation services are provided to patients seen previously by the physiatrist for consultation or assessment. The fee is not meant as an administrative fee for supervising a department of rehabilitation nor is it to be charged on the same day as claims are made for any other services which are provided by the physiatrist to the same patient(s). **This fee applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services of physical or occupational therapy, speech therapy and discharge planning**	2.30

PLASTIC SURGERY (08)

General Listings:

A085	Consultation	39.75
A086	Repeat consultation	31.90
A083	Specific assessment	28.50
A084	Partial assessment	15.00

Emergency or O.P.D. – Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patient Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C085	Consultation		39.75
C086	Repeat consultation		31.90
C083	Specific assessment		28.50
C084	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C082	up to five weeks	per visit	13.10
C087	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C089	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C088	Concurrent care (minor assessments)	per visit	13.10

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	PLASTIC SURGERY–Cont'd.	
	Long Term Institutional Care – Chronic and Convalescent Hospital, Homes for the Aged – Patients Covered by Extended Care Legislation and Nursing Homes:	
W085	Consultation	$39.75
W086	Repeat consultation	31.90
	PSYCHIATRY (19)	
	General Listings:	
A195	Consultation	82.50
A395	Limited consultation	54.00
A196	Repeat consultation	54.00
A193	Specific assessment	43.50
A194	Partial assessment	18.00
	Emergency or O.P.D.–Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings	
	Non-Emergency Hospital Services: (in-patient, day care, night care, residential care – see para. B39 of Preamble – for emergency calls or other special visits to patients use General Listings and Premiums [para. B42 of Preamble] when applicable).	
C195	Consultation	82.50
C395	Limited consultation	54.00
C196	Repeat consultation	54.00
C193	Specific assessment	43.50
C194	Specific re-assessment	31.50
	Subsequent visits: (minor assessments)	
C192	up to five weeks ... per visit	13.10
C197	from sixth to thirteenth week inclusive (not to exceed $39.30 per week) ... per visit	13.10
C199	after thirteenth week (not to exceed $78.60 per month) ... per visit	13.10
C198	Concurrent care (minor assessments) ... per visit	13.10
	Long Term Institutional Care – Chronic and Convalescent Hospital, Homes for the Aged – Patients Covered by Extended Care Legislation and Nursing Homes:	
W195	Consultation	82.50
W395	Limited consultation	54.00
W196	Repeat consultation	54.00
	Other Services:	
N.C.	Specific assessment with report to referring agency	N.A.B.
	Consultation on behalf of disturbed child (including report):	
A197	consultative interview with parents	77.25
A198	consultative interview with child	77.25
	(Assessment conference with parents to be charged on the basis of family therapy.)	
N.C.	Therapeutic supervision with any para-medical organization (health education, correction and other community resources)	N.A.B.
N.C.	Appearance before Advisory Review Board or Review Board – per ½ hour or major part thereof	N.A.B.
K620	Consultation for involuntary psychiatric treatment (as mandated by Section 35(4B) of the Mental Health Act) – per ½ hour or major part thereof	38.90
	Interviews with relatives on behalf of a patient, C.A.S. or legal guardian etc. – see Practice in General Listings (p. 2)	
	Certification of Mental Illness	
K623	Application for psychiatric assessment, (as mandated by the Mental Health Act)–including necessary history, examination, **notification of the patient, family and relevant authorities** and completion of form	63.75
K624	Certification, of involuntary admission (as required by the Mental Health Act including history, examination, **notification of the patient, family and relevant authorities** and completion of form	75.00
N.C.	Certification of incompetence (financial) including assessment to determine incompetence	N.A.B.
K629	All other re-certification(s) of involuntary admission	22.50

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	PSYCHIATRY–Cont'd.	
	Psychotherapy: (see preamble)	
	Individual **outpatient psychotherapy** (including aversive conditioning, narcoanalysis, psychoanalysis)	
K197	per ½ hour or major part thereof	$38.90
	Individual inpatient psychotherapy (including aversive conditioning, narcoanalysis, psychoanalysis)	
K190	**per ½ hour or major part thereof**	**38.90**
	Group psychotherapy–out-patients	
K203	per member, per ½ hour or major part thereof (up to six hours per day)–4 people	9.75
K204	–5 people	7.90
K205	–6-12 people	6.90
N.C.	per member, per ½ hour (seventh to ninth hour per day.)	N.A.B.
	Group psychotherapy–in-patients	
K200	per member, per ½ hour or major part thereof (up to six hours per day)–4 people	9.75
K201	–5 people	7.90
K202	–6-12 people	6.90
N.C.	per member, per ½ hour (seventh to ninth hour per day)	N.A.B.
	Family therapy–**outpatients** (two or more family members)	
K195	per ½ hour or major part thereof	45.00
	Family therapy–in-patients (two or more family members)	
K193	**per ½ hour or major part thereof**	**45.00**
	Hypnotherapy:	
K192	Individual–per ½ hour or major part thereof	38.90
	Group–for induction and training for hypnosis (up to eight people) per ½ hour or major part	
K194	thereof–per member	7.90

Notes: (1) For electrotherapy fees, see Diagnostic and Therapeutic Procedures.

(2) **Individual** psychotherapy or hypnotherapy or counselling are not to be charged in conjunction with other consultations or visits rendered by a physician on the same day unless there are clearly defined different diagnoses for the two services.

(3) When charging group therapy, the smaller (4 or 5 people) or larger group (6-12 people) is to be charged for but not **more than one** for the same group.

RADIOLOGY–DIAGNOSTIC (33)

Code		
	General Listings:	
A335	Consultation	21.00
	Non-Emergency Hospital Service:	
C335	Consultation	21.00

RADIATION ONCOLOGY–(THERAPEUTIC RADIOLOGY) (34)

Code			
	General Listings:		
A345	Consultation		54.00
A745	**Limited consultation**		**47.60**
A346	Repeat consultation		36.00
A343	Specific assessment		31.90
A344	Partial assessment		16.50
	Non-Emergency Hospital In-Patient Services:		
C345	Consultation		54.00
C745	**Limited consultation**		**47.60**
C346	Repeat consultation		36.00
C343	Specific assessment		31.90
C344	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C342	up to five weeks	per visit	13.10
C347	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C349	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C348	Concurrent Care (minor assessments)	per visit	13.10

Premiums for Special Visits by Physicians, Detention Visits to I.C.U or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code

UROLOGY (35)

General Listings:

A355	Consultation*		$39.75
A356	Repeat consultation*		32.25
A353	Specific assessment*		28.90
A354	Partial assessment		15.00

Emergency or O.P.D.—Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patients Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C355	Consultation*		39.75
C356	Repeat consultation*		32.25
C353	Specific assessment*		28.90
C354	Specific re-assessment		18.00
	Subsequent visits: (minor assessments)		
C352	up to five weeks	per visit	13.10
C357	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C359	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C358	Concurrent care (minor assessments)	per visit	13.10

Long Term Institutional Care—Chronic and Convalescent Hospital, Homes for the Aged—Patients Covered by Extended Care Legislation and Nursing Homes:

W355	Consultation*		39.75
W356	Repeat consultation*		32.25

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

A615	Consultation		82.50
A655	Limited consultation		54.00
A616	Repeat consultation		54.00
A613	General assessment		43.50
A614	General re-assessment		31.50
A618	Partial assessment		18.00

Emergency or O.P.D.:—Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patients Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C615	Consultation		82.50
C655	Limited consultation		54.00
C616	Repeat consultation		54.00
C613	General assessment		43.50
C614	General re-assessment		31.50
	Subsequent visits (minor assessments):		
C612	up to five weeks	per visit	13.10
C617	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C619	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C618	Concurrent care (minor assessments)		13.10

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

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*May include physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration, catheterization and prostatic fluid examination, but not to include endoscopic examination.

CONSULTATIONS AND VISITS

GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code			
A415	Consultation		$82.50
A545	Limited consultation		54.00
A416	Repeat consultation		54.00
A413	General assessment		43.50
A414	General re-assessment		31.50
A418	Partial assessment		18.00

Emergency or O.P.D.:–Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patients Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Code			
C415	Consultation		82.50
C545	Limited consultation		54.00
C416	Repeat consultation		54.00
C413	General assessment		43.50
C414	General re-assessment		31.50
	Subsequent visits (minor assessments):		
C412	up to five weeks	per visit	13.10
C417	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C419	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C418	Concurrent care (minor assessments)		13.10

CLINICAL IMMUNOLOGY (62)

For Services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code			
A625	Consultation		82.50
A525	Limited consultation		54.00
A626	Repeat consultation		54.00
A623	General assessment		43.50
A624	General re-assessment		31.50
A628	Partial assessment		18.00

Emergency or O.P.D.:–Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patients Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Code			
C625	Consultation		82.50
C525	Limited consultation		54.00
C626	Repeat consultation		54.00
C623	General assessment		43.50
C624	General re-assessment		31.50
	Subsequent visits (minor assessments):		
C622	up to five weeks	per visit	13.10
C627	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C629	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C628	Concurrent care (minor assessments)		13.10

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 23, 24)

CONSULTATIONS AND VISITS

Code **CARDIOLOGY (60)**

For Services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code		
A605	Consultation	82.50
A645	Limited consultation	54.00
A606	Repeat consultation	54.00
A603	General assessment	43.50
A604	General re-assessment	31.50
A608	Partial assessment	18.00

Emergency or O.P.D.:—Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-Emergency Hospital In-Patients Services: (see para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Code			
C605	Consultation		82.50
C645	Limited consultation		54.00
C606	Repeat consultation		54.00
C603	General assessment		43.50
C604	General re-assessment		31.50
	Subsequent visits (minor assessments):		
C602	up to five weeks	per visit	13.10
C607	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C609	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C608	Concurrent care (minor assessments)		13.10

REPIRATORY DISEASE (47)

For Services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code		
A475	Consultation	82.50
A575	Limited consultation	54.00
A476	Repeat consultation	54.00
A473	General assessment	43.50
A474	General re-assessment	31.50
A478	Partial assessment	18.00

Emergency or O.P.D.:—Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

(para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

Code			
C475	Consultation		82.50
C575	Limited consultation		54.00
C476	Repeat consultation		54.00
C473	General assessment		43.50
C474	General re-assessment		31.50
	Subsequent visits (minor assessments):		
C472	up to five weeks	per visit	13.10

Premiums for Special Visits by Physicians, Detention Visits to I.C.U or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

CONSULTATIONS AND VISITS

Code	**RESPIRATORY DISEASE (47)**—Cont'd.		
C477	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	$13.10
C479	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C478	Concurrent care (minor assessments)		13.10

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

A485	Consultation	82.50
A595	Limited consultation	54.00
A486	Repeat consultation	54.00
A483	General assessment	43.50
A484	General re-assessment	31.50
A488	Partial assessment	18.00

Emergency or O.P.D.:—Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: – use General Listings

Non-emergency Hospital In-patient Services:

(para. B39 of Preamble – for emergency calls and other special visits to in-patients, use General Listings and Premiums [para. B42 of Preamble] when applicable).

C485	Consultation		82.50
C595	Limited consultation		54.00
C486	Repeat consultation		54.00
C483	General assessment		43.50
C484	General re-assessment		31.50
	Subsequent visits (minor assessments):		
C482	up to five weeks	per visit	13.10
C487	from sixth to thirteenth week inclusive (not to exceed $39.30 per week)	per visit	13.10
C489	after thirteenth week (not to exceed $78.60 per month)	per visit	13.10
C488	Concurrent care (minor assessments)		13.10

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 23, 24)

Long Term Institutional Care—Chronic and Convalescent Hospital, Homes for the Aged—Patients Covered by Extended Care Legislation and Nursing Homes:

Premiums for Special Visits by Physicians, Detention, Visits to I.C.U. or C.C.U. Chargeable in Addition to Above Fees – see para. B42-45 of Preamble.

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*May include physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration, catheterization and prostatic fluid examination, but not to include endoscopic examination.

LABORATORY MEDICINE

PREAMBLE:

1. The patient documentation and specimen handling benefit is applicable to all patients, except for those items listed under the anatomical pathology, histology and cytology sections. The items in this section have been left at a sufficient level to cover any administrative costs. This benefit is not applicable to referred in samples, since the collecting laboratory will already have claimed the patient documentation and specimen collection benefit.
2. The biochemistry section has been condensed so that one listing refers to a procedure for any of amniotic fluid (A), blood (B), C.S.F. (C), faeces (F), gastrointestinal fluid (G), urine (U). Exceptions are indicated by B, U, etc., following the test name. Other specimens will be considered on an I.C. basis.
3. A number of tests are listed in different sections of the schedule i.e. when more than one method of performing the test is available e.g. Hepatitis B antigen is listed under both Radioassays and Immunology. Assays of ligand type other than isotopic are listed under Biochemistry.
4. Blood glucose by the dipstick method may be claimed only when assessed by an appropriate instrument such as a reflectance meter. It should not be claimed when used only as a check on the fasting blood sample of a glucose tolerance test. The blood glucose of the fasting sample in a glucose tolerance test is allowable only once even if assessed by two methods.
   Note: The standard glucose tolerance test for diagnosis of diabetes mellitus (L104) consists of 5 blood specimens taken at 0, 30, 60, 90 and 120 minutes following oral administration of 75 g of glucose. In pregnancy (L103), 4 specimens only are to be taken at 0, 60, 120 and 180 minutes. (see: CMAJ *126*, 473 (1982)). **When 5 hour glucose tolerance is specifically ordered, the blood glucose measurements are to be claimed individually using code L111.**
5. Code L418 or L417 may not be claimed by a physician in addition to claim(s) for any treatment or assessment. However, Code G481 (see page 48) may be claimed by a physician if a hemoglobin screen (any method or instrument) is carried out in the course of an office or home visit. Urinalysis (on page 48) may be claimed with or without an associated visit to a physician's office (except for screening and urinalyses which are not medically necessary).
6. When a screening culture method (e.g. Agar spoon) is used on a urine sample, L641 refers to a culture technique and does not apply to those kits using the nitrite test only. Where a significant growth is obtained and followed up by definitive identification methods, L633 or L634 only should be claimed. The benefits for L633 or L634 include any necessary microscopic examination of the urine.
7. The physician assumes responsibility for all cytology smears and the listed professional benefits (L804 to L815 inclusive) are weighted averages of the professional component. These benefits, therefore, are applicable in each case whether or not all slides are examined by the physician.
8. Only those tests which are requested are to be claimed for with the following exceptions. It is intended that if the test results yield abnormal findings or information which would be incomplete, insufficient or meaningless to the referring physician, the medical director of a laboratory may add further appropriate tests and claim for them with the knowledge he may have to substantiate their justification.
9. A test must be completed in accordance with the pertinent schedule listing in order to claim for it. The verbatim listing is intended as the definitive benefit for that test alone, unless otherwise specified e.g. isoenzymes do not include total enzyme estimation; creatine does include creatinine (as specified). Notwithstanding the foregoing and recognizing that it is impossible to list all variations in techniques of all listed tests, when there is a modification of the usual technique, the listing most closely approximating it should be used.
10. This schedule, with the exception of L036, lists actual procedures performed. No claim shall be made for calculated values made and reported, or for control tests or repeat tests on same patient sample.
11. The benefit for seminal fluid examination (complete) is to include sperm count, volume estimation, motility and morphology and viscosity. The benefit of **$3.00** for seminal fluid examination carried out post-vasectomy is not to be claimed by the operating surgeon unless the patient requires more than one office visit post-operatively.
12. Creatinine is a justifiable addition in the case of tests on 24-hour urine samples, where it is necessary to assess the sample as a complete 24-hour collection. However, if several tests (e.g. steroids) are done on a single such sample, only one creatinine would be claimed for that sample. In those estimations where the test result is expressed in terms of creatinine excretion the performance of a creatinine is mandatory and should be claimed.
13. It is recognized that in requests for a serologic titre, if a screening test is used and would suffice, the lesser benefit for the screening test should be claimed. If positive and followed by

serial titration, both the screening and titre fees should be claimed. If the titration is a micro technique using plates, it is the equivalent of a tube titre, the wells being miniature tubes.

14. When a test for trichomonas identification (any method) is carried out in association with L625 or L627, wet preparation (L653) may be claimed in addition. L653 may be claimed when a Wet Preparation is used for direct examination of a fresh specimen for vegetative amoebae or similar parasites. However, the wet preparation used in the fæces concentration technique for parasites and ova is included in L650.
    The conditions set down in paragraph 8 of this preamble must be adhered to.
15. It is recognized that in all laboratory tests there is a professional component.
16. The maximum number of units which can be claimed for any combination of L418 (Hemoglobin), L417 (Hematocrit), L399 (WBC Count) and L397 (RBC Count) is 11 units per patient per day, whether automated, semi-automated or manual methods are used. L700 is not included in this total and should be claimed separately, if appropriate. Laboratories using multichannel equipment should use individual codes as described above.
17. The maximum number of units which can be claimed for any combination of the tests represented by the following codes will be 40 LMS units per patient visit per day:

    L005
    L030
    L045
    L053
    L061
    L067
    L111
    L191
    L194
    L204
    L208
    L222
    L223
    L225
    L226
    L251
    L252

    The maximum of 40 units applies on a per patient basis, regardless of the number of specimens submitted and regardless of the number of laboratories involved in performing the individual tests. Code L700 is not included in this maximum and should be claimed separately if appropriate.
18. The maximum number of units which may be claimed for any combination of chemical analyses performed on a single sample by means of an automated chemical analyzer with simultaneously functioning channels is 18 LMS units (L225).
19. The following preamble applies to the blood bank section:
    (a.) L471 Antibody Identification – incomplete antibodies. A panel of any number of cells regardless of suspending media or technique used. Preparation of eluate and/or antibody absorption is included.
    (b.) L472 Antibody Identification – complete antibodies. A panel of any number of cells for the identification of complete antibodies by direct agglutination.
    (c.) L473 Parallel Titration – New code to be used when two sequential patient serum specimens are tested to detect a change in antibody titre. Includes a repeat antibody identification on the current sample.
    (d.) L490 Blood Group – ABO and $RH_o(D)$. The subgroups of A and RhD^u are included where indicated. A direct AHGT is also included in L490, therefore, L495 may not be charged on the same patient when this code is claimed.
    (e.) L492 Crossmatch. When an initial crossmatch is requested the appropriate claim is for L490 x 1, L482 x 1 plus L492 for each unit ordered. L490 and L482 may not be claimed more than once on the same day of service. L490 and L493 may not be claimed when these procedures are carried out as a confirmatory test on the units of blood to be transfused.
    (f.) L493. This code includes L490 (see preamble d.) and Rh genotype to include the antigens C, D, E, c, e, and D^u when indicated. Any other antigen is to be claimed under L494.
    (g.) L494 Blood Group per antigen. Antigens stated in L493 and L490 are excluded from this code.
    (h.) L495 Direct AHGT – can be used when ordered as a single procedure, or in addition to L482 when the latter is requested as a single procedure. L495 may not be claimed when L490 or L493 is claimed with L482 on the same patient on the same visit.
20. Antibiotic sensitivities should not be done routinely, but only when, by reason of its identification and/or its concentration, the isolated organism has a high probability of being pathogenic. L621 applies to all routine antibiotic sensitivity testing regardless of the method used and including MIC determination by manual kit or automated methodologies.
21. The use of Nickersons Medium as a screening test for yeast is not a benefit.
22. The carcinoembryonic antigen test (CEA) L690 is not to be used as a general cancer screen. It is to be used only for following established malignancies.
23. This preamble is intended to apply to everyone using codes L700, L001 to L731, L800 to L837 and L900 to L919.
24. Fees for laboratory medicine testing are not refundable (in whole or in part) to the referring physician or referring laboratory by the laboratory performing the tests.

LABORATORY MEDICINE

25. The benefits for patient documentation and specimen collection and each test are calculated by multiplying the individual L.M.S. Unit values by **46.3¢.**
26. Laboratory tests on specimens sent outside Ontario are not a benefit of the Plan.
27. **Secondary** Laboratories receiving specimens for additional (secondary) tests from another Laboratory that normally would be claimed as L303, L319 or L500 should be claimed as L903, L919 or L900 respectively.

Code		**LMS Units**
L700	**PATIENT DOCUMENTATION AND SPECIMEN COLLECTION FEE**	7

1. Limited to 1 per patient, per day.
2. Not allowed to the recipient of a referred sample from another laboratory.
3. Not allowed to the attending physician.
4. Not applicable to a patient visit solely to receive instructions or collection containers.
5. When multiple tests are ordered for the same patient for the same day, only one L700 may be claimed even though all specimens may not be available on any one day.
6. Not applicable to items under anatomical pathology, histology and cytology section. (Fee codes L701 to L731 inclusive, **L800 to L837 or L900 to L919 inclusive.**)

BIOCHEMISTRY

(Applicable to all specimens except as denoted by B-blood, U-urine, F-fæces, C-CSF., A-amniotic fluid).

L059	Acetaminophen	25
L001	Acetone, Qualitative	3
L002	Acetone, Quantitative	35
L003	Addis count–U	32
L004	Albumin, Qualitative	3
L005	Albumin, Quantitative (excluded if globulin and/or protein electrophoresis done)	10
L006	Alcohol, Ethyl–Quantitative	43
L007	Alcohols, Qualitative	25
L008	Alcohols, Fractionation and Quantification	45
L009	Aldolase	30
L010	Aldosterone	120
L011	Amino Acids–one way chromatography–B, U	15
L012	Amino Acids–two way chromatography–U	30
L013	Amino Acids, Fractionation and Quantitation	200
L014	Amino Acid Nitrogen	33
L071	Aminoglycosides (Gentamicin, Tobramycin)	40
L020	Aminophylline, Quantitative (theophylline)	40
L015	Ammonia	39
L016	Amniotic Fluid Scan	20
L017	Amniotic Fluid L/S Ratio	50
L018	Amylase	22
L021	Androstenedione	75
L019	Ascorbic Acid	25
L025	Barbiturates, Qualitative	25
L026	Barbiturates, Quantitative	35
L027	Barbiturates, Fractionation and Quantification	60
L028	Bile microscopy	4
L029	Bilirubin, Qualitative–F	3
L030	Bilirubin, total	10
L031	Bilirubin, conjugated	10
	Blood gases (see listings on page 19)	
L037	Blood Volume–excluding injection of dye	20
L038	Bromides	15
L039	Bromosulphthalein (BSP) excluding injection of dye	14
L045	Calcium	10
L046	Calcium Ionized	20
L047	Calculus analysis–chemical, Qualitative	15
L048	Calculus analysis, Qualitative and Quantitative	25
L073	Cannabinoid	35
L040	Carbamazepine, Quantitative (Tegretol)	35

LABORATORY MEDICINE

Code		LMS Units
L049	Carotene	16
L050	Catecholamines, total	60
L051	Catecholamines, fractionated	80
L052	Ceruloplasmin	19
L041	Chlordiazepoxide, Quantitative (Librium)	40
L053	Chloride	6
L054	Chloride (sweat)	33
L055	Cholesterol, total–not to be charged with L156	14
L056	Cholesterol, ester–not to be charged with L156	14
L057	Cholinesterase–pseudo or true	30
L058	Cholinesterase Genotyping (includes pseudo, Dibucaine and Fluoride)	50
L060	Carboxyhemoglobin	15
L061	CO_2 Content, CO_2 Combining Power, Bicarbonate (measured, not calculated)	6
L062	Chymotrypsin	22
L063	Copper	40
L064	Cortisol	35
L065	Creatine (includes creatinine)	26
L066	Creatine Phosphokinase	25
L070	Creatine Phosphokinase, fractionation	34
L067	Creatinine (not with L068)	6
L068	Creatinine Clearance	15
L075	Crystal Identification (x-ray powder diffraction analysis)	30
L069	Cystine Screening–U	8
L074	Diazepam, Quantitative (Valium, Vivol)	40
L072	Digoxin	45
L077	Diphenylhydantoin, Quantitative (phenytoin, Dilantin)	35
L076	Disopyramide	35
L078	Drug Screen	20
L079	Drug Screening **with** chromatographic confirmation	75
L085	Electrophoresis, serum–including total protein	36
L086	Electrophoresis, other than serum–including total protein	50
L080	Electrophoresis, serum–alone	26
L087	Estradiol	75
L088	Estriol–B	75
L089	Estriol, Pregnancy–U	50
L090	Estrogens, total–U	50
L091	Estrone	75
L092	Ethosuximide, Quantitative (Zarontin)	35
L095	Fat, total–F	72
L096	Fat, Differential–F	92
L097	Fat and/or meat fibres (microscopic)–F	6
L098	Fat (microscopic)–U	6
L099	Fatty Acids, free	25
L094	Flurazepam, Quantitative (Dalmane)	40
L100	F.S.H. (Pituitary Gonadotrophins)	60
L105	Galactose (per sample)	16
L106	Galactose-1-phosphate uridyl transferase (quantitative)	65
L113	Galactose-1-phosphate uridyl transferase (screening)	10
L107	Gamma glutamyl transpeptidase	15
L109	Gastric analysis titration (per sample)	7
L110	Globulin (excluded if albumin and/or protein electrophoresis done)	10
L111	Glucose, quantitative (not by dipstick)	6
L112	Glucose, semi-quantitative (dipstick if read with reflectance meter)	3
L104	Glucose tolerance test	30
L103	Glucose tolerance test in pregnancy	24
L114	Glutathione	20
L115	Glycoproteins	60
L093	Glycosylated hemoglobin – $HgbA_1$	22
L116	Gold	40
L119	Hexoseaminidase A	15
L120	Haptoglobin	15
L132	Hemoglobin A_2 by column chromatography	25

LABORATORY MEDICINE

Code		LMS Units
L121	5HIAA Screening–U	9
L122	5HIAA Quantitation–U	50
L117	High Density Lipoprotein Cholesterol	18
L118	Histamine	90
L123	Homogentisic Acid (Qualitative)	9
L101	Homovanillic Acid, HVA	60
L124	Hydroxy Butyrate Dehydrogenase	10
L125	17-Hydroxycorticosteroids–U	34
L126	17-Ketogenic steroids–U	40
L127	17-Ketosteroids, total–U	34
L128	17-Ketosteroids, fractionated–U	80
L129	Hydroxyproline–B	25
L130	Hydroxyproline, Total–U	90
L131	Hydroxyproline, Total and Free–U	150
L135	Inulin Clearance Test	40
L136	Insulin	40
L142	Intestinal enzymes–qualitative	6
L143	–quantitative	22
L137	Iodine Protein Bound	21
L139	Iron, Total–with iron binding capacity	34
L141	Iso-Citric Dehydrogenase	15
L145	Lactic Acid (lactate)	27
L146	Lactic Dehydrogenase (L.D.H.), total	10
L147	Lactic Dehydrogenase Fractionation	29
L148	Lead	40
L149	Leucine Aminopeptidase	15
L159	Lidocaine	35
L150	Lipase	22
L151	Lipid (total)	16
L152	Lipids (Thin Layer Chromatography)	30
L153	Lipoprotein, Electrophoresis-not to be charged with L156	34
L154	Lipoprotein, Ultracentrifugation	50
L155	Lipoprotein Lipase (Frederickson)	100
L156	Lipoprotein phenotyping (includes sample appearance, cholesterol, triglycerides, lipoprotein, electrophoresis and interpretation)–not to be charged with L055, L153 or L243	69
L157	Lithium	10
L158	Luteinizing Hormone (LH), chemical (not immunologic)	60
L165	Magnesium	13
L166	Malic Dehydrogenase	15
L167	Melanin–U	10
L168	Mercury	30
L169	Metanephrines, total–U	75
L170	Metanephrines, fractionated–U	90
L163	Methadone	15
L171	Methemalbumin	21
L172	Methemoglobin	21
L160	Methotrexate (Amethopterin)	35
L1[illegible]	Methylphenidate, quantitative (Ritalin)	40
L164	Morphine	15
L173	Mucopolysaccharides–U	25
L174	Myoglobin, Qualitative–U	30
L161	N-acetylprocainamide	35
L180	5'-Nucleotidase	25
L181	Occult blood	3
L182	Ornithine Carbonyl Transferase	15
L183	Osmolality (osmolarity)	10
L184	Oxalic Acid – U	40
L185	P.A.H. Clearance	40
L081	Phenobarbitone (Luminal)	35
L032	pCO_2	8
L033	pO_2 (arterial)	8
L034	pH	7

LABORATORY MEDICINE

Code		LMS Units
L035	pCO_2, pO_2 and pH in combination	17
L036	pCO_2, pO_2,pH-calculation of one or more of standard bicarbonate, base excess, etc.	3
L187	Phenothiazines, Qualitative–U	6
L188	Phenothiazines, Quantitative–U	30
L189	Phenylalanine	15
L190	Phosphatase, Acid	15
L191	Phosphatase, Alkaline	10
L192	Phosphatase, Alkaline fractionation	29
L193	Phospholipids	30
L194	Phosphorus (inorganic phosphate)	10
L195	Plasma Clearing Factor (Baker)	35
L196	Plasma Hemoglobin	15
L197	Porphobilinogen (PBG), screen–U	10
L198	Porphobilinogen (PBG), Quantitative–U	25
L199	Delta-aminolevulinic Acid (ALA), Quantitative–U	25
L200	Porphyrins, screen	10
L201	Porphyrins, Quantitation (copro, proto, uro)–U	60
L202	Porphyrins, Quantitation (copro, proto, uro)–B	75
L203	Porphyrins, Quantitation (copro, proto, uro)–F	90
L204	Potassium	6
L205	Pregnanediol–U	70
L206	Pregnanetriol–U	80
L211	Primidone, Quantitative (Mysoline)	35
L212	Procainamide	35
L207	Progesterone	50
L214	Propoxyphene	35
L213	Propranolol	35
L208	Protein, total–not to be charged with L085 or L086	10
L209	PSP (Phenolsulphonphthalein)	15
L210	Pyruvic Acid (pyruvate)	27
L215	Quinidine	18
L216	Reducing substances, identified by chromatography	30
L220	Salicylate, Qualitative	5
L221	Salicylate, Quantitative	12
L222	SGOT (AST)	10
L223	SGTP (ALT)	10
L225	Automated chemical analyzers with simultaneously functioning channels (single sample)	18
L226	Sodium	6
L227	Spectroscopic examination (any)	20
L228	Sulphemoglobin	21
L229	Sulphonamides	27
L230	T-4, Total (Thyroxine)	24
L240	Thiocyanates	15
L242	Thyroxine–Binding Globulin	50
L243	Triglycerides–not to be charged with L156	21
L244	Trypsin	22
L250	Urea Clearance	15
L251	Urea Nitrogen (B.U.N.)	6
L252	Uric Acid	6
L253	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of S.G., pH, protein, sugar, hemoglobin, ketones, urobilinogen, bilirubin)	7
L254	Urinalysis, one or more parts of above without microscopy	3
L267	Urobilin, Qualitative–U	7
L255	Urobilinogen, Qualitative–U	7
L256	Urobilinogen, Quantitative–U	15
L257	Valproic Acid	35
L260	Vitamin A	30
L261	VMA (Vanilmandelic Acid)	60
L265	Xylose Absorption Test (per specimen)	6
L266	Zinc	25
L299	Biochemical assays not included above	I.C.

Note: Biochemical assays other than specifically listed are not a benefit as such until approved by OHIP.

LABORATORY MEDICINE

Code		LMS units
	RADIOASSAYS and LIGAND ASSAYS –The following listings are to be used if **the assay involves the use of a radioisotope, enzyme or fluorescent label.**	
L307	ACTH (Adrenocorticotrophic Hormone)	120
L300	Aldosterone	120
L691	Alphafetoprotein	45
L304	Aminoglycosides	40
L321	Aminophylline (Theophylline)	40
L305	Androstenedione	75
L322	Anti-DNA	45
L323	Anti-RNA	45
L301	Calcitonin	120
L302	C–AMP (Cyclic Adenosine Monophosphate)	60
L346	C-peptide Immunoreactivity	60
L690	Carcinoembryonic antigen (CEA)	I.C.
L303	Cortisol	35
L903	**Cortisol, secondary Laboratory**	**35**
L347	Dehydroepiandrostenedione	75
L605	**1, 25 Dihydroxy Vitamine D**	**120**
L306	Digoxin	45
L324	Diphenylhydantoin (Phenytoin), Quantitative (Dilantin)	35
L310	Estradiol	75
L311	Estriol	75
L312	Estrogens–total–U	50
L313	Estrone	75
L329	Ferritin	45
L308	Folate, serum–not to be billed in addition to L309	45
L309	Folate, in red cells, to include serum folate and hematocrit	98
L315	FSH (Pituitary Gonadotrophins)	60
L316	Gastrin	75
L317	Growth Hormone	40
L318	HCG (Human Chorionic Gonadotrophins)	50
L319	Hepatitis associated or antibody immunoassay – per assay, e.g. Hepatitis B surface antigen or antibody, hepatitis B anticore antibody, hepatitis A antibody	45
L919	Hepatitis associated antigen or antibody radio-immunoassay by secondary Laboratory per assay	45
L693	Hormone receptors for carcinoma (to include estrogen and/or progesterone assays)	I.C.
L320	HPL (Human Placental Lactogen)	50
L606	**25 Hydroxy Vitamin D**	**80**
L334	IgE	45
L688	Immune Complexes by Clq binding	60
L689	Immune Complexes by Raji cell assay	100
L325	Insulin	40
L326	Insulin antibodies	80
L327	Iron binding capacity	24
L328	LH (Luteinizing Hormone)	60
L330	Parathyroid Hormone	120
L343	Phenobarbitone	35
L348	Proinsulin immunoassay	500
L331	Progesterone	50
L333	17-OH Progesterone	60
L332	Prolactin	75
L335	Renin	75
L336	T-3, Total (Triiodothyronine)	40
L337	T-3 Uptake	18
L607	**Free T-3**	**50**
L338	T-4, Total (Thyroxine)	24
L339	T-4, Free–Absolute (includes T-4 total)	50
L340	Testosterone	50
L608	**Free Testosterone**	**100**
L341	TSH (Thyroid Stimulating Hormone)	50
L609	**Thyroglobulin**	**80**
L342	Thyroxine Binding Globulin (T.B.G.)	50

LABORATORY MEDICINE

Code		LMS Units
L345	Vitamin B_{12}	45
L585	**Ligand** Assays – not included above	I.C.
	Note: Radio-immuno assays other than specifically listed are not a benefit as such until approved by OHIP.	
	HEMATOLOGY	
L370	Assay of Factors II, V, VII, VIII, IX, X, XI and XII (each)	55
L371	Autohemolysis test	24
L372	Blood film examination (to include differential, red cell morphology and platelet estimate)	10
L374	Blood film–buffy coat preparation–not to be charged with L430	18
L375	Blood film–special stain	11
L376	Bleeding time–Duke method	8
L377	Bleeding time–Ivy method	15
L378	Bone marrow–film preparation	15
L379	Bone marrow–staining (Romanowski and iron)	23
L385	Capillary fragility	7
L386	Circulating anticoagulant	10
L387	Clot observation for lysis	7
L388	Clot lysis, dilute whole blood	10
L389	Clot retraction	6
L390	Clotting time (Lee and White)	8
L391	C.S.F. cell count (to include differential)	18
L395	Eosinophil count	8
L396	Platelet count	10
L397	R.B.C. count, excluding manual method (see preamble)	4
L398	Reticulocyte count	13
L399	W.B.C. count	4
L400	Euglobulin clot lysis	20
L401	Fibrinogen, semi-quantitative	6
L402	Fibrinogen, quantitative	28
L403	Factor XIII (Urea solubility test)	5
L404	Fibrinolysis (plate method)	16
L405	Fibrin split products, quantitative	30
L406	Fibrin split products, latex screening	5
L407	Folate, serum	45
L408	Folate, in red cells, to include serum folate and hematocrit	98
L410	G-6-PD screen	10
L411	G-6-PD quantitative assay	65
L412	Pyruvate kinase quantitative assay	65
L415	Haptoglobin	15
L416	Heinz bodies	15
L417	Hematocrit	3
L418	Hemoglobin	4
L419	Hemoglobin electrophoresis to include Hb A_2 fraction	34
L420	Hemoglobin, fetal	20
L421	Hemoglobins, unstable	6
L422	Hemolysins–Ham's Acid Serum test	18
L423	Hemolysins–cold (Donath-Landsteiner)	18
L424	Hemosiderin in urine	11
L430	L.E. Cell prep–not to be charged with L374	18
L431	Kleihauer stain	18
L432	Malaria smear or other parasites	15
L435	Plasmapheresis	50
L436	Platelet function–aggregation, per additive	12
L437	Platelet function–adhesiveness	25
L438	Platelet function–thromboplastic function (PF-3)	28
L439	Preparation of cryoprecipitate (per treatment)	17
L440	platelet concentrates (per treatment)	25
L441	washed red cells	35
L442	leukocyte-poor blood	20
L443	Protamine titration	15
L444	Protamine sulphate test	10

LABORATORY MEDICINE

Code		LMS Units
L445	Prothrombin time	8
L446	Prothrombin consumption	10
L450	Osmotic fragility	45
L447	Reptilase time	10
L451	Sedimentation rate	4
L452	Sickle cell preparation	14
L453	Sickle cell solubility test (screen)	5
L455	Special stains for acute leukaemia	75
L454	Sucrose hemolysis	18
L456	Terminal transferase by immunofluorescence	75
L460	Thrombin time	10
L461	Thromboplastin generation test	71
L462	Partial thromboplastin time	10
L465	Vitamin B_{12}, microbiologic, not isotopic	45
	BLOOD BANK	
L471	Antibody Identification – incomplete antibody. To be claimed only if L482 is positive or doubtful. See preamble 19a.	45
L472	Antibody Identification – complete antibody. To be claimed only if L482 is positive or doubtful. See preamble 19b.	30
L481	Antibody Titre per antibody regardless of method used. To be claimed only if either L471 or L472 yielded positive identification	15
L482	Antibody screening	16
L473	Parallel Titration on two specimens to include confirmation of previously detected antibody. See preamble 19c.	75
L490	Blood Group – ABO and $Rh_o(D)$. See preamble 19d.	13
L492	Crossmatch per unit of blood. See preamble 19e.	10
L493	Blood Group – ABO and Rh Genotype. See preamble 19f.	40
L494	Blood Group per antigen. See preamble 19g.	8
L495	Direct Anti-Human Globulin Test. See Preamble 19h.	4
	IMMUNOLOGY	
	Single gel diffusion and nephelometric quantitative assays	
L550	Immunoglobulin G, A, D, M	12
L560	Complement proteins–Clq	12
L551	$C_3(B_1C)$	12
L552	$C_4(B_1E)$	12
L557	C_5	12
L558	C_3 proactivator	12
L561	C_1 esterase inactivator	12
L553	Miscellaneous proteins–Ceruloplasmin	12
L554	Transferrin	12
L555	$Alpha_1$ antitrypsin	12
L556	$Alpha_2$ macroglobulin	12
	Immunoelectrophoresis	
L575	Maximum 3 antisera per test serum; fee per antiserum used –monoclonal gammopathy screen –L chains –H chains	30
L576	Cryoglobulin characterization	30
	Double gel diffusion, qualitative (Ouchterlony) per antigen	
L568	–Antibodies to food antigens (milk, wheat proteins) or fungal antigens (allergic alveolitis screening series)–maximum of 4 antisera per patient screen	5
L567	– Cl esterase inactivator screen	5
L565	–Alphafetoprotein screen	5
L566	–Immunoglobulins, L chains, H chains	5

LABORATORY MEDICINE

Code		LMS Units
	Miscellaneous Agglutination Reactions	
	eg.	
	Rheumatoid factor	
	Antithyroid (thyroglobulin or microsomal)	
	Streptolysin screen	
L500	Screen	6
L900	Screen by secondary Laboratory	6
L502	Serial tube 4 or more antigens	30
L501	Titre– serial tube single antigen	15
L660	Cold agglutinins–screen	6
L661	–titre	15
L595	Alphafetoprotein–screen	15
L596	Anti sperm antibodies–screen	20
L597	–titre	40
L665	C-Reactive Protein	6
L655	Pregnancy test	6
L598	Pregnancy test titre	15
	Cellular Assays	
L520	Nitroblue Tetrazolium test–screen for enzyme deficiency	30
L522	Leukocyte chemotactic activity	150
L521	Intracellular leukocyte bacterial killing capacity	100
L523	Leukocyte phagocytic capacity	40
L524	Lymphocyte activation (transformation) by isotope incorporation (limited to 3 mitogens and/or antigens)	200
L525	Lymphocyte surface immunoglobulins by immunofluorescence	200
L526	Lymphocyte T and B cell rosettes	200
L527	Mixed lymphocyte reaction	300
L528	Antibody dependent cellular cytoxicity	200
L529	Naturally occurring cell cytoxicity	200
L532	Caffeine stimulation test	300
L533	ATP depletion test	275
	Complement–kinetic (activity) assays	
L530	Total Hæmolytic complement (CH50 non-kit)	50
L531	Complement components (activity assays)	60
	Fluorescent Antibody Tests (Immunofluorescent Studies)	
	Tests for serum antibodies to tissue and cell components (codes L535 and L544) should be claimed per type of tissue section examined and per serum dilution used, irrespective of number of antibodies identified, maximum four slides.	
L544	antinuclear	35
L535	antimitochondrial	50
	antithyroid	
	antiadrenal	
	antismooth muscle	
	antiparietal	
	antiskin	
	antisperm	
L545	Protein deposition in tissues (per tissue examined, any number of antisera, e.g. immunoglobulin, complement component, fibrinogen and pathogens, etc.)	75
	Histocompatibility Testing	
L580	Tissue typing	200
L581	Crossmatch	50
L582	Antibody screening (per panel of 15 antigens)	150
L583	HLA 27 typing	50
	Microbial Immunology	
L659	Antistreptolysin 0,7 tube titrations or micro technique	25
L662	Complement fixation, screen	20
L663	titre, single antigen	30
L664	multiple antigens	50
L667	Direct fluorescent antibody (not with L624-L634)	12
L682	For each additional antibody add	4
L683	For Indirect fluorescent antibody	15

LABORATORY MEDICINE

Code		LMS Units
L684	For each additional antibody add	5
L668	Heterophile antibodies–screen (slide or single tube) with or without absorption	5
L670	Heterophile antibodies–with absorption by guinea pig kidney and ox cells, multiple tube titres (Paul Bunnell)	30
L658	Trichinella antibody	6
L679	Virus antibodies–hæmagglutination inhibition or ELISA technique	30
L680	Virus antibodies–neutralization test	40
L681	Virus antibodies sucrose gradient separation of IgM plus inhibition test	90
N.C.	VDRL (Patient Out of the Province – L999)	5
L503	Widal slide or tube agglutination	25
L319	Hepatitis associated antigen or antibody radioimmunoassay–per assay e.g. hepatitis B surface antigen or antibody hepatitis B anticore antibody hepatitis A antibody	45
	Miscellaneous	
L599	Cryofibrinogen–Qualitative	5
L600	Cryoglobulin–Qualitative	5
L601	Cryoglobulin–Quantitative	30
L602	Pyroglobulin–Qualitative	5
L604	Serum viscosity–relative	10
L603	–quantitative	20
	Radioimmunoassay–see listings under Radioassays	
	Modifiers (units in addition to units for basic test where applicable–immunologic procedures)	
L610	Concentration of sample before testing (any method)	2
L611	Radio-modification of standard technique utilizing isotope labelled reagents, e.g. anti-insulin, anti-diptheria, anti-tetanus	50
	–immunoelectrophoresis –double diffusion –radial diffusion	
	Preparation of special antigens or antisera	IC
	Special investigations	IC
	MICROBIOLOGY	
L620	Antibiotic level, serum	40
L621	Antibiotic sensitivity–per organism, max. of 2 per specimen	9
L623	–M.I.C.–one antibiotic, tube or agar dilution	25
L622	Chlamydia isolation	55
L624	Cultures–blood (including aerobic, anærobic, subcultures, smears) per bottle	30
L625	–cervical, vaginal, including GC culture, Gram smear, yeast identification (e.g. Germ tube)–not to be charged with L627	25
L639	–fluids (CSF, joint, pleural etc. not exudates)	28
L626	–fungus, including KOH preparation and smear–not to be charged with L625	20
L627	–GC culture and smear–not to be charged with L625	20
L628	–other swabs or pus–culture and smear	25
L629	–sputum–culture and smear	22
L630	–stool, including necessary agglutinations	33
L640	–throat swab, for streptococcus, screen only	6
L631	–tuberculosis, including ZN or fluorescent smear	55
L632	animal inoculation	100
L641	–urine, screening, actual culture without identification–see Preamble	7
L633	–urine, pour plate or Miles-Misra quantitation	20
L634	–urine, calibrated loop quantitation	15
L642	Lysozyme inhibition test	13
L635	Pathogenic E coli (as sole procedure in infants only, such as fluorescent staining, not with L630)	5
L656	Penicillinase production	8
L636	Streptococcus grouping, Lancefield **or other direct agglutinotion methods**	18
L638	Streptococcus grouping, coagglutination method	12
L637	Virus isolation	50
	Microscopy	
L645	Darkfield (spirochetes)	10
L646	Electron–direct, for viruses	40

LABORATORY MEDICINE

Code		LMS Units
L647	–immunoelectron microscopy	60
L648	–after ultracentrifugation	65
L649	–thin section, for virus	130
L650	Parasites and ova (fæces concentration)	20
L654	Parasites and ova, smear only, special stain	20
L651	Pinworm (Scotch tape prep)	5
L643	Smear only, Gram or Papanicolaou stain, as sole procedure (not with L624-L634)	5
L652	Smear only, special stain, e.g. ZN, inclusions, spores, diphtheria	14
L653	Wet preparation (for fungus, trichomonas, parasites)	3

ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY

Note: Do not claim L700 in addition to codes L701 to L731 or L800 to L837.

The items listed in this section include only the technical component of the various items listed. The professional component for each item where applicable is listed in the following section.

Code		LMS Units
N.C.	Autopsy, gross and microscopic (including CNS as required)	N.A.B.
N.C.	Referred – in organs, gross and microscopic	N.A.B.
N.C.	**Removal of brain and/or spinal cord**	N.A.B.
	Chromosome Analysis	
L701	Chromosome banding	70
L702	Karyotype of blood or bone marrow	300
L703	Karyotype of skin or amnion cells	475
	Cytology and Histology	
L704	Amniotic fluid for fetal maturation	8
L705	Aspiration biopsy (lung, breast, thyroid, etc.)	32
L706	Bronchial washings or brushings, per specimen	14
L707	Buccal or vaginal smear for Barr body	8
L708	Esophageal, gastric or endometrial washings or brushings	14
L709	Esophageal and gastric washings (including collection)	33
L710	Direct smears–oral, larynx, nipple discharge, vulvar	13
L711	Fluids (pleural, ascitic, cyst, aspirate pericardial, CSF, urine and joint)	13
L712	Fluorescent Y chromosome	8
L713	Cervicovaginal specimen (including all types of cellular abnormality, assessment of flora and/or cytohormonal evaluation)	13
L714	Smear for inclusion bodies	8
L715	Smear for eosinophils (nasal, sputum, ocular, etc.)	3
L716	Sputum per specimen for general and/or specified assessment, (e.g., cellular abnormality, asbestos bodies, lipid, hemosiderin, etc.)	14
L717	Electron microscopy	225
L726	Analytical electron microscopy–elemental detection, mapping or electron diffraction, per specimen	40
L723	Metabolic bone study–morphologic and morphometric assessment	250
L724	Metabolic bone study–kinetic assessment including fluorescent label studies	30
L725	X-ray diffraction analysis of calculi	30
L718	Seminal fluid examination (complete)–see Preamble	22
L719	Smear for spermatozoa only (post-operative)	7
L720	Surgical pathology	16
L721	Operative consultation–with or without frozen section (up to three specimens)	15
L722	For each specimen over 3, add	8
L727	Nerve teasing for demyelination	50
L728	Histochemistry of muscle – 1 to 3 enzymes	40
L729	– each additional enzyme, per label	13
L730	Morphometry, e.g. muscle fibre, nerve fascicles, cells	75
L731	Immunoperoxidase technique–per label (maximum of 3 per specimen)	75

ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY (Professional components only)

Code		LMS Units
N.C.	Autopsy, gross and micro (including CNS as required)	N.A.B.
N.C.	Referred–in organs, gross and microscopic–each	N.A.B.
N.C.	**Removal of brain and/or spinal cord**	N.A.B.

LABORATORY MEDICINE

Code		LMS Units
L800	Blood film interpretation	$10.05
L826	Special stains for acute leukemia, with written report	9.50
Z403	Bone marrow aspiration	24.75
L802	Bone marrow interpretation	34.00
L830	Terminal transferase by immunofluorescence	9.50
L803	Chromosome analysis, per case	46.50
	Cytology	
L804	Amniotic fluid for estimation of fetal maturation	3.00
L805	Aspiration biopsy (lung, breast, thyroid, etc.)	12.40
L806	Bronchial washings or brushings, per specimen	7.60
L807	Buccal or vaginal smear for Barr body	3.70
L808	Direct smears–oral, larynx, nipple discharge, vulvar	3.30
L809	Esophageal, gastric or endometrial washings or brushings, per complete specimen	7.60
L810	Fluids (pleural, ascitic, cyst, pericardial, CSF, urine and joint) per specimen	4.75
L811	Fluorescent Y chromosome (peripheral blood)	4.75
L812	Cervicovaginal specimen (including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation)	3.25
L813	Smear for inclusion bodies	4.75
L814	Smear for eosinophils (nasal, sputum, ocular, etc.)	1.45
L815	Sputum per specimen for general and/or specific assessment (e.g. cellular abnormalities, asbestos bodies, lipid, hemosiderin, etc)	4.75
L816	Electron microscopy, transmission or scanning, per case, per technique	75.20
L831	Analytical electron microscopy-elemental detection, mapping or electron diffraction–per specimen	37.20
	Immunofluorescence studies	
L817	Anti-tissue antibodies, per case	4.75
L818	Protein deposition in tissues, per case	17.55
L819	Seminal fluid examination, complete	6.40
L820	Smear for spermatozoa only	2.95
L821	Surgical pathology, sections and report per case	17.55
L822	Operative consultation – with or without frozen section (up to three specimens)	35.95
L823	For each specimen over three, add	17.55
	Synovial fluid analysis	
L824	Description, viscosity and mucin clot	4.75
L825	Identification of crystals by compensated polarized light	9.75
L801	Metabolic bone studies	62.00
L832	X-ray diffraction analysis of calculi	17.55
L833	Nerve teasing for demyelination	35.10
L834	Histochemistry of muscle–1 to 3 enzymes	17.55
L835	– each additional enzyme	5.90
L836	Morphometry, e.g. muscle fibre, nerve fascicles, cells	17.55
L837	Immunoperoxidase techniques–per label (maximum of 3 per specimen)	4.80
L827	Interpretation of carcinoembryonic antigen (C.E.A.)	4.10
L828	Interpretation of R.I.A. for hormone receptors for carcinoma (to include estrogen and/or progesterone assays)	5.10
L829	Imprint and/or touch preparation (with or without special stains)	7.60

NUCLEAR MEDICINE–IN VIVO

Column T – is the technical benefit for the production of records, radiopharmaceutical agents, apparatus, premises, technical services, administration and secretarial services.

Column P_1 – is the professional benefit for supervision of the procedure, appropriate patient interview and/or examination, correlation of related data, interpretation of results, and provision of a written report. The physician need not be continuously present in the nuclear medicine department or private facility while the procedures are being carried out but must be physically present frequently enough to carry out the appropriate patient interview and/or examination and approve, modify or intervene in the procedures as required.

Column P_2 – is the professional benefit for interpretation of results and provision of a written report. If the physician does not meet the criteria for P_1 or has claimed any visit in conjunction with that Nuclear Medicine procedure, the lesser professional fee (P_2) will be claimed.

Notes:

1. If quantification or data manipulation is carried out in addition to visual inspection of imaging studies, add 30% to the appropriate professional benefit. For claim purposes, use prefix "Y". Such activity must add significant diagnostic information not available by inspection alone and does not include simple image enhancement techniques such as smoothing, background subtraction, etc. Recording of images on videotape for replay and production of images on the video display of a computer do not in themselves justify the additional benefit.
   The claims for cardiac wall motion studies and calculation of ventricular ejection fraction (Z010 and Z012) already include an allowance for data manipulation as a general rule and no additional benefit may be claimed. The additional computer benefit may be claimed only when additional cardiac quantifications are performed i.e. stroke volume ratio and volume response curves and/or phase analysis.
2. The total benefit is arrived at by adding T plus P_1 (first code listed e.g. Z006) or by adding T plus P_2 (second code listed, e.g. Z925).
3. Examination of Brain, Lung, Liver or Spleen is limited to one view, the benefit (T and P_1 or P_2) is to be reduced by 50%.
4. Repeat studies on the same day may be claimed only after exercise or drug intervention.
5. The phrase "nuclear medicine specialist" should be interpreted as "nuclear medicine physician" since not all physicians practising nuclear medicine are certified as specialists in this discipline by the Royal College of Physicians and Surgeons.

Code		T	P_1	P_2
	Cardiovascular System			
Z006/Z925	Arteriography – aorta and its branches – uni or bilateral	$ 74.40	$ 22.50	$ 11.00
Z008/Z927	Venography – uni or bilateral	74.40	25.30	12.40
Z013/Z928	– mediastinum and superior vena cava	44.70	25.30	12.40
Z007/Z926	Blood flow study in conjunction with static organ scan	29.70	12.70	6.15
Z004/Z922	Cardiac output	29.70	15.10	7.40
Z024/Z924	Cardioangiography	74.40	22.50	12.40
Z005/Z991	Myocardial perfusion scan – with Thallium^{201}	154.60	26.30	13.40
Z025/Z994	Delayed Thallium^{201} myocardial perfusion scan	29.70	26.30	13.40
Z017/Z964	Myocardial perfusion scan – using other radionuclides	82.65	26.30	13.40
Z016/Z960	Myocardial scan – acute infarction, injury	74.40	22.50	11.00
Z010/Z923	Myocardial wall motion studies – two or more projections	98.80	44.90	22.05
Z009/Z992	–repeat same day (maximum of three repeats)	29.70	22.50	–
Z012/Z988	Myocardial wall motion studies with ejection fraction	98.80	60.00	29.55
Z011/Z993	–repeat same day (maximum of three repeats)	29.70	30.10	–
Z018/Z965	Pericardial effusion scan	41.70	15.10	7.40
Z023/Z983	Detection and localization of venous thrombosis using radio iodonated fibrinogen up to ten days	98.80	23.30	11.50
	Endocrine System			
Z022/Z982	Adrenal scan	154.60	37.65	7.40
Z027/Z930	Thyroid uptake – per determination	21.50	12.10	3.00
Z078/Z974	Thyroid scan	52.05	22.20	7.40
Z019/Z975	Thyroid scan with uptake using same radiopharmaceutical	63.70	34.20	7.40
Z074/Z971	Parathyroid scan	74.40	25.30	7.40
	Gastrointestinal System			
Z040/Z934	Radio-labelled fat absorption study	26.40	7.60	7.40
Z043/Z936	Schilling test	42.20	7.60	7.40
Z044/Z937	Schilling test – repeat with intrinsic factor or other	21.10	3.75	3.70
Z015/Z938	Schilling test with dual isotopes and intrinsic factor	42.20	9.75	9.60
Z057/Z939	C^{14} labelled metabolite breath test	49.60	7.60	7.40
Z045/Z940	Protein loss or gastrointestinal bleeding	74.40	15.10	14.80

NUCLEAR MEDICINE–IN VIVO

Code	GASTROINTESTINAL SYSTEM–Cont'd.	T	P1	P2
Z046/Z941	Ca^{47} absorption study	$ 74.40	$ 15.10	$ 14.80
Z031/Z996	Oesophageal motility study in the supine or upright position, liquid or solid bolus	74.40	25.30	11.00
Z032/Z997	–repeat (maximum of three repeats)	37.20	12.60	5.50
Z042/Z942	Gastrointestinal transit or reflux study	74.40	25.30	11.00
Z088/Z977	Abdominal scan (ectopic gastric mucosa, GI bleed, and shunt patency	74.40	22.50	11.35
Z047/Z943	Pancreatic secretion study (Selenium)	154.60	15.70	7.65
Z073/Z970	Pancreatic scan	154.60	25.30	12.40
Z058/Z951	Dynamic biliary excretion	74.40	25.30	12.40
Z070/Z966	Liver and/or spleen scan	74.40	22.50	11.00
Z089/Z978	Salivary gland study	74.40	25.30	12.40
	Genitourinary System			
Z063/Z953	Dynamic renal imaging study	74.40	25.30	12.40
Z060/Z952	Renogram (time-activity curves only)	41.30	15.10	7.40
Z076/Z973	Renal scan (static image only)	52.05	15.10	7.40
Z061/Z954	Renal plasma flow	41.30	15.70	7.65
Z062/Z955	Glomerular filtration rate	49.60	15.70	7.65
Z026/Z956	Cystogram for vesicoureteral reflux	74.40	25.30	12.40
Z075/Z972	Placenta	49.60	15.10	7.40
Z021/Z981	Testicles and scrotum	69.15	25.30	7.40
	Hematopoietic System			
Z001/Z919	Plasma volume	21.50	5.25	5.10
Z002/Z920	Plasma volume with repeat studies	29.70	5.25	5.10
Z003/Z921	Red cell volume	31.40	4.50	4.40
Z050/Z945	Plasma iron clearance	52.90	7.60	7.40
Z051/Z946	Plasma iron turnover	52.90	7.60	7.40
Z052/Z947	Fe^{59} red cell utilization	52.90	15.10	7.40
Z053/Z948	Combination of Z050, Z051, Z052 at one time	115.70	15.10	14.80
Z054/Z949	Red or white cell or platelet survival	74.40	23.50	11.50
Z055/Z950	Red or white cell or platelet survival and serial surface counts	115.70	31.30	15.40
	Musculoskeletal System			
Z065/Z961	Whole body survey – bones, joints, soft tissue, marrow	99.20	34.50	16.95
Z049/Z962	Specific site – one or more	66.15	25.30	12.40
Z038/Z958	Whole body^{67} gallium or radioactive indium scanning	124.00	37.60	18.45
Z039/Z959	^{67}Gallium scanning or radioactive indium specific site	90.90	26.20	13.40
Z056/Z984	Bone mineral density by Gamma ray scattering	26.40	7.60	7.40
Z092/Z985	Total body calcium	–	15.80	7.70
Z035/Z995	Bone mineral content of lumbar spine or femoral neck by dual-photon absorbtiometry	127.35	32.60	16.30
	Z065/Z961 and Z049/Z962 are not to be billed together. Z007/Z926 may be claimed in addition to Z065/Z961 or Z049/Z962 for blood pool study.			
	Nervous System			
Z064/Z979	Cerebral spinal fluid circulation	105.80	41.90	20.55
Z066/Z963	Brain scan	74.40	25.90	13.70
	Respiratory System			
Z071/Z967	Lung scan – ventilation or perfusion	74.40	27.00	11.00
Z059/Z968	– ventilation and perfusion on same day	111.60	40.95	20.10
	Miscellaneous			
Z091/Z980	Lymphangiogram	74.40	25.30	12.40
Z072/Z969	Ocular tumour localization	52.90	43.35	7.40
Z087/Z976	Tear duct –unilateral	66.15	18.80	9.20
Z085/Z989	– bilateral	74.40	22.50	11.00
Z033/Z986	Whole body counting	–	15.70	7.65

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES

Such procedural benefits are intended for the professional service of placing an instrument or introducing diagnostic radiopharmaceuticals. They are not intended to be used for simple subcutaneous, intramuscular or intravenous injection nor for oral administration. Rather than double listing the procedures and benefits in this part of the fee schedule, physicians are directed to the following reference points in the schedule.

a) Intravenous injection for peripheral venography-G376 or G379 on page 48
b) Intra-articular injections-G370 on page 47
c) Injection into CSF spaces or shunt apparatus-Z801 or Z821 on page 125
d) Arterial puncture-G479 on pages 40 & 41
e) Paracentesis in conjunction with shunt patency study – Z590 on page 108

NUCLEAR MEDICINE – IN VITRO (see Radioassays under Laboratory Medicine.)

RADIATION ONCOLOGY (THERAPEUTIC RADIOLOGY)

Code		
	RADIOTHERAPY (including Therapeutic Isotopes)	
	The listed benefits are for the professional services of a certified therapeutic radiologist, the services of a specialist for the intracavitary or interstitial application of radium or sealed sources and the services of a specialist using non-sealed sources of radioisotopes in a laboratory authorized by the Atomic Energy Control Board of Canada. Other medical services to the patient are not included in these figures. The cost of material is additional.	
	TELERADIOTHERAPY	
X301	Major treatment planning (150 KVP or higher), dosage calculation and preparation of any special treatment device	$ 45.40
X302	Teleradiotherapy–x-ray, 151 KVP or higher, radium, cobalt, cesium betatron linear accelerator–benefit per treatment visit	11.60
X304	Minor teleradiotherapy–x-ray, 150 KVP or less–benefit per treatment visit	7.65
	Note: For minor teleradiotherapy administered by other than certified therapeutic radiologists, use the listing under Diagnostic and Therapeutic Procedures.	
	RADIUM AND RADIOISOTOPES (sealed sources)	
X322	Treatment planning, dosage calculation and preparation of any special treatment device	45.40
	Intracavitary application of radium or sealed sources including dilatation and curettage carried out at same time as application	
X323	–first application	135.00
X334	–repeat application	67.50
X324	Interstitial application of radium or sealed radioisotope	133.50
X325	Application of radium or radioisotope plaque or mould	41.25
	RADIOISOTOPES (non-sealed sources)	
	The following benefits include treatment planning, dosage calculation and preparation of materials. Appropriate visit and procedural benefits (e.g. paracentesis) may be claimed in addition. Thyroid benefits (X326, X327, X335) include administration(s) within any three month period.	
X326	Thyroid malignancy	60.00
X327	Hyperthyroidism	54.60
X335	Induction of hypothyroidism	54.60
X336	Prostate malignancy	54.60
X328	Polycythæmia	31.90
X329	Metastatic disease of bone	49.60
X330	Ascites and/or pleural effusion(s) due to malignancy	38.85
X332	Arthritis–single or multiple site	25.65
X333	Metastatic disease with radioactive lymphogram	38.85

DIAGNOSTIC RADIOLOGY

Column T – The benefit for radiological examination including the production of radiographs, supplying of contrast media, apparatus, premises, technical services, administration and collection costs.

Column P – The benefit for consultation between radiologist and referring physician, fluoroscopy, interpretation of radiographs and fluoroscopic findings and supervision of x-ray services by a radiologist.

Hospital out-patient technical fees will be paid at 91.43% of the technical fee listed in this Schedule of Benefits.

Private offices and hospital outpatient departments will bill Column T plus P.

Radiologists should use Column P as a guideline for negotiating remuneration with hospitals.

Benefits for clinical procedures related to x-ray examinations are listed in the following section, or under Diagnostic and Therapeutic or Surgical Procedures. "Clinical Procedures", in this context, are those by which contrast media are introduced, except oral or rectal administration for study of the alimentary tract, and intravenous injections, which are an integral part of the study, performed by the physician collecting the benefit for the procedure.

If less than minimum number of views are performed, reduce listed fees by 25%.

If the examinations which are requested by the referring physician yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient, governed by the needs of the patient and the requirements of the referring physician, the radiologist may add further views and charge for them (if listed).

Fee Schedule Interpretations

1. When a radiologist is asked to x-ray one extremity only, no additional charge should be made for comparison x-rays initiated by the radiologist.

2. Nephrotomography is covered by the listings for intravenous pyelogram and planigram.

3. A stereo pair is to be counted as two views.

4. No extra claim should be charged for rapid sequence I.V.P.

5. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.

6. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examination, e.g. examinations of the G.I. tract, urinary tract, special procedures.

7. "Colon-air contrast" may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.

8. "Oesophagus, stomach and duodenum, double contrast" presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.

9. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.

10. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.

11. Chest studies should not be routinely done and claimed in mammography cases.

12. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examination requests.

13. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.

14. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who should have the power to determine what examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed a single film is usually inadequate.

15. Conventional films of the spine should not be routinely done and claimed for before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they had been done at an outside office, then it is a matter for the radiologist and the referring physician to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required examination of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.

16. Pharynx and oesophagus (cine or videotape) – X106 should not be claimed routinely with X108 and X109 but only when specifically indicated.

17. Lumbar or lumbosacral spine (X028) does not include the entire sacrum. An examination of the sacrum may be carried out and claimed for only when specifically indicated.

18. X006 and X007 are not both to be **routinely** claimed on the same patient **but only when specifically indicated.**

19. A maximum of two computed tomography examinations per patient per day may be claimed.

20. All benefits listed apply to unilateral examinations unless otherwise specified.

21. Claims for X-ray services, when referred by an Osteopath, Chiropodist or Chiropractor to a private X-ray facility are not benefits of OHIP.

22. Claims for X-ray services, when referred by an Osteopath or Chiropractor to a hospital outpatient department are benefits.

DIAGNOSTIC RADIOLOGY

Code	**Head and Neck**	T	P
X001	Skull–four views	$26.30	$8.70
X009	–five or more views	32.85	10.70
X003	Sella turcica (when skull not examined)	13.10	4.20
X004	Facial bones–minimum of three views	19.10	6.80
X005	Nose– minimum of two views	13.10	4.20
X006	Mandible–minimum of three views (uni or bilateral)	19.10	6.80
X012	–four or more views	26.30	8.70
X007	Temporomandibular joints–minimum of four views including open and closed mouth views	19.10	6.80
X008	Sinuses–minimum of three views	19.10	6.80
X010	Mastoids–bilateral–minimum of six views	25.30	9.45
X011	Internal auditory meati (when skull not examined)	19.10	6.80
N.C.	Teeth, up to ¼ set	N.A.B.	N.A.B.
N.C.	Teeth, up to ½ set	N.A.B.	N.A.B.
N.C.	Teeth, full set	N.A.B.	N.A.B.
N.C.	Teeth, bite wing	N.A.B.	N.A.B.
X016	Eye, for foreign body	13.00	6.00
X017	Eye, for localization, additional	13.50	15.45
X018	Optic foramina	14.80	6.00
X019	Salivary gland region	12.10	5.20
X020	Neck for soft tissues–minimum of two views	12.10	5.20
	Spine and Pelvis		
X025	Cervical spine–two or three views	22.80	5.20
X202	–four or five views	29.40	7.00
X203	–six or more views	35.55	8.60
X027	Thoracic spine–two views	20.90	5.20
X204	–three or more views	27.40	6.90
X028	Lumbar or lumbosacral spine–two or three views	22.80	5.20
X205	–four or five views	29.40	7.00
X206	–six or more views	35.60	8.70
X032	Entire spine–(scoliosis series) minimum of four views	47.20	13.65
	–Orthoroentgenogram (3 foot film)		
X033	–single view	19.10	6.80
X031	–two or more views	26.25	8.55
X034	Sacrum and/or coccyx–two views	22.00	4.20
X207	–three or more views	27.40	6.90
X035	Sacro-iliac joints–two or three views	19.10	6.80
X208	–four or more views	25.50	8.55
X036	Pelvis and/or hip(s)–one view	13.10	4.20
X037	–two views (e.g. A.P. and frog view, both hips; or A.P. both hips plus lateral one hip)	24.45	6.00
X038	–three or more views (e.g. pelvis and sacro-iliac joints, or A.P. both hips plus lateral each hip)	28.10	6.80
	Upper Extremities		
X045	Clavicle–two views	13.10	4.20
X209	–three or more views	20.20	6.00
	Acromioclavicular joints (bilateral) with or without weighted distraction		
X046	–two views	19.10	6.80
X210	–three or more views	26.10	8.55
X047	Sternoclavicular joints–(bilateral)–two or three views	15.70	5.20
X211	–four or more views	22.70	6.90
X048	Shoulder–two views	15.70	5.20
X212	–three or more views	22.70	6.90
X049	Scapula–two views	15.70	5.20
X213	–three or more views	22.70	6.90
X050	Humerus–including one joint–two views	13.10	4.20
X214	–three or more views	20.20	6.00
X051	Elbow–two views	13.10	4.20
X215	–three or four views	20.20	6.00
X216	–five or more views	27.20	7.65
X052	Forearm, including one joint–two views	13.10	4.20
X217	–three or more views	20.20	6.00
X053	Wrist–two or three views	13.10	4.20

DIAGNOSTIC RADIOLOGY

Code	**Upper Extremities**–Cont'd.	T	P
X218	–four or more views	$20.20	$ 6.00
X054	Hand–two or three views	13.10	4.20
X219	–four or more views	20.20	6.00
X055	Wrist and hand–two or three views	19.10	8.55
X220	–four or more views	24.30	10.20
X056	Finger or thumb–two views	10.10	3.00
X221	–three or more views	13.10	4.20
	Lower Extremities		
X060	Hip–(unilateral)–two or more views	20.90	5.20
X063	Femur, including one joint–two views	13.10	4.20
X223	–three or more views	20.20	6.00
X065	Knee (including patella)–two views	13.10	4.20
X224	–three or four views	20.20	6.00
X225	–five or more views	27.20	7.65
X066	Tibia and fibula (including one joint)–two views	13.10	4.20
X226	–three or more views	20.20	6.00
X067	Ankle–two or three views	13.10	4.20
X227	–four or more views	20.20	6.00
X068	Calcaneus–two views	13.10	4.20
X228	–three or more views	20.20	6.00
X069	Foot–two or three views	13.10	4.20
X229	–four or more views	20.20	6.00
X072	Toe–two views	10.10	3.00
X230	–three or more views	13.10	4.20
X064	Leg length studies (Orthoroentgenogram)	19.10	6.80
	Skeletal Surveys		
	Skeletal survey for bone age,		
X057	–single film	13.10	4.20
X058	–two or more films or views	19.30	6.90
	Other survey studies–e.g., rheumatoid, metabolic or metastatic		
X080	–basic	6.50	2.20
X081	–plus per film or view	6.50	2.20
	Chest		
N.C.	Miniature chest film–for survey purposes only	N.A.B.	N.A.B.
X090	Single film	13.10	4.20
X091	Two views	19.30	6.90
X092	Three or more views	24.80	8.20
X039	Ribs–two or more views	15.70	5.20
X040	Sternum–two or more views	15.70	5.20
X096	Thoracic inlet–two or more views	13.10	4.20
	Abdomen		
X100	Single view	13.10	4.20
X101	Two or more views	20.10	6.00
	G.I. Tract		
X105	Palatopharyngeal analysis (cine or videotape)	25.95	17.10
X106	Pharynx and œsophagus (cine or videotape)	25.95	17.10
X107	Oesophagus–when X103, X104, X108 or X109 not billed	23.50	11.10
X108	Oesophagus, stomach and duodenum–including survey film if taken	40.80	19.80
X104	Oesophagus, stomach and duodenum–double contrast, including survey film, if taken	42.45	21.70
X103	Oesophagus, stomach and duodenum–double contrast, including survey film, if taken, and small bowel	53.70	27.50
X109	Oesophagus, stomach and small bowel	52.00	25.65
X110	Hypotonic duodenogram	34.70	17.10
X111	Small bowel only–**when only examination performed during patient's visit**	23.50	11.10
X112	Colon–barium enema (including survey film, if taken)	42.50	18.00
X113	Colon–air contrast, primary or secondary, including survey films	53.80	23.30
X114	Gallbladder (one or multiple day examinations)	26.30	8.70
X120	Gallbladder (one or multiple day examinations with preliminary plain film)	35.00	8.70

DIAGNOSTIC RADIOLOGY

Code	G.I. Tract–Cont'd.	T	P
X116	T-Tube cholangiogram	$ 19.10	$ 6.80
X117	Operative cholangiogram	19.10	6.80
X118	Intravenous cholangiogram	43.60	15.40
X123	Operative pancreatogram or E.R.C.P.	19.10	6.80
	G.U. Tract		
X129	Retrograde pyelogram, unilateral or bilateral	19.10	6.80
X130	Intravenous pyelogram including preliminary film	43.65	17.10
X137	Cystogram (catheter)	21.00	5.20
X135	Cystourethrogram, stress or voiding (catheter)	24.30	10.20
X131	Cystourethrogram (non-catheter)	5.10	3.50
X191	Intestinal conduit examination or nephrostogram	19.10	6.80
X138	Percutaneous antegrade pyelogram	19.10	6.80
X139	Percutaneous nephrostomy	19.10	6.80
X134	Urethrogram (retrograde)	15.70	5.20
X136	Vasogram	15.70	5.20
	Obstetrics and Gynaecology		
X143	Survey film	13.10	4.20
X144	Pelvimetry	19.10	6.80
X145	Placentogram	19.10	6.80
X146	Any combination of above	33.10	10.20
X147	Hysterosalpingogram	26.25	8.55
X148	Intra-uterine fœtal transfusion–radiological control	34.70	17.10
	Fluoroscopy–by physician with or without spot films		
X195	Chest	8.20	8.55
X196	Skeleton	8.20	8.55
X197	Abdomen	8.20	8.55
X189	Fluoroscopic control of clinical procedures done by another physician per ¼ hour	6.45	14.30
	Special Examinations		
X155	Abdominal or pelvic pneumogram	35.20	8.55
	Angiography		
	–by catheterization		
	–abdominal, thoracic, cervical or cranial		
	–using single films		
X179	non-selective	26.25	8.55
X180	selective (per vessel to a max. of 4)	34.70	17.10
	–using film changer, Cine or multiformat camera		
X181	non-selective	52.50	17.10
X182	selective (per vessel to a max. of 4)	69.90	25.65
X140	selective (6 or more vessels)	I.C.	I.C.
	Carotid angiogram–direct puncture		
X160	–unilateral	43.05	25.65
X161	–bilateral	69.20	38.60
	Peripheral angiogram		
X174	–unilateral	26.25	8.55
X175	–bilateral	34.70	17.10
X198	Splenoportogram	52.10	17.10
X199	Translumbar aortogram	52.10	17.10
	Vertebral angiogram–direct puncture or retrograde brachial injection		
X132	–unilateral	43.05	25.65
X133	–bilateral	70.40	38.60
X156	Arthrogram	23.10	18.90
X200	–with fluoroscopy and complete positioning throughout by physician	32.40	27.45
X157	Bone density (mineral content) measurement	29.50	13.65
X158	Bronchogram–unilateral	25.80	17.10
X159	–bilateral	34.30	25.65
X162	Cerebral stereotaxis	52.50	17.10
X122	Cholangiogram, percutaneous trans-hepatic	26.00	12.80

DIAGNOSTIC RADIOLOGY

Code	Computed tomography	T	P
X400	–head–without I.V. contrast	–	$ 32.25
X401	–with I.V. contrast	–	48.40
X188	–with and without I.V. contrast	–	56.40
X403	–neck–without I.V. contrast	–	32.25
X404	–with I.V. contrast	–	48.40
X124	–with and without I.V. contrast	–	56.40
X406	–thorax–without I.V. contrast	–	48.40
X407	–with I.V. contrast	–	56.40
X125	–with and without I.V. contrast	–	64.50
X409	–abdomen–without I.V. contrast	–	64.50
X410	–with I.V. contrast	–	72.60
X126	–with and without I.V. contrast	–	80.60
	–extremities (one or more)		
X412	–without I.V. contrast	–	32.25
X413	–with I.V. contrast	–	48.40
X127	–with and without I.V. contrast	–	56.40
X415	–spine–without I.V. contrast	–	64.50
X416	–with I.V. contrast	–	72.60
X128	–with and without I.V. contrast	–	80.60
X151	Cordotomy, percutaneous	$ 43.05	25.65
X163	Dacrocystogram	26.25	8.55
X164	Discogram(s)–one or more levels	25.80	17.10
X167	Fistula or sinus injection	19.10	6.80
X169	Laminogram, planigram, tomogram	35.20	8.55
X170	Laryngogram	25.80	17.10
X171	Lymphangiogram	43.60	17.10
X192	Mammary ductography	19.10	6.80
X184	Mammogram–unilateral	21.80	9.40
X185	–bilateral	32.40	14.10
X186	–using xeroradiography–unilateral	27.00	9.40
X187	–bilateral	41.50	14.10
X150	Mechanical evaluation of knee	22.50	12.00
X193	Microradioscopy of the hands	12.90	8.55
X173	Myelogram (spine and/or posterior fossa)	30.80	20.60
X190	Pantomography	15.70	5.20
X154	Penis	14.10	3.45
X165	Photographic subtraction	–	8.55
X176	Sialogram	26.25	8.55
X177	Skin thickness measurement	13.80	6.80
X183	Ventriculogram or pneumoencephalogram	43.05	25.65
X166	Examination using portable machine in home, add to first examination only	55.65	–

Note: This code does not apply to the use of a portable machine in a hospital. Can only be claimed once per day regardless of the number of people x-rayed in the same home.

CLINICAL PROCEDURES, ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Note 1. These procedural fees are intended to cover compensation for the professional service of placing an instrument and introducing contrast media if done (except oral or rectal administration for study of the alimentary tract). Injection of materials to enhance the effect of contrast media is included in the procedure benefits.

2. Radiological charges are additional: see similar entries under section on RADIOLOGY.
3. Where similar procedures are done for diagnostic physiological studies of non-radiological nature, e.g. cardiac catheterization or intra-arterial infusion, they are listed separately under Surgery or Diagnostic and Therapeutic Procedures. See Index.

Code		Specialist	Anæsthetist
	Angiography		
	–by catheterization		
	–abdominal, thoracic, cervical or cranial		
J021	Insertion of catheter (including cut down, if necessary) and injection, if given	$ 79.30	5

CLINICAL PROCEDURES, ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Code		Specialist	Anæsthetist
J022	Selective catheterization – add to catheter insertion fee (per vessel to maximum of four), each	$ 39.70	
J014	Selective catheterization (spinal and parathyroid angiography) – add to catheter insertion fee – per vessel each	19.80	
	("Selective" means manipulation of the catheter from the vessel of introduction into a branch, tributary, or cardiac chamber with angiogram(s))		
J031	Carotid angiogram–direct puncture	63.20	5
J025	Transluminal angioplasty including angiography with or without pressure measurements – one or more sites or vessels	206.55	5
J048	Percutaneous trans-hepatic catheter portal venography	161.10	5
J027	Peripheral arteriogram–direct puncture	39.70	4
J026	Peripheral venogram–direct puncture	31.80	4
	Selective coronary catheterization including angiogram, see G293 and G297, page 42		
J033	Splenoportogram	63.20	4
J034	Trans-lumbar aortogram	63.20	5
J032	Vertebral angiogram–direct puncture or by retrograde brachial injection	63.20	5
J040	Embolization e.g. for treatment of hemangioma or renal carcinoma –first vessel, charge appropriate angiographic procedural and radiological fees plus	54.50	
J047	–each addition vessel catheterized and occluded, per vessel	25.60	
J023	Intra-arterial infusion of drugs e.g. for control of gastrointestinal hæmorrhage–charge appropriate angiographic procedural and radiological fees plus a per diem supervision fee of	15.30	
J035	Pressure measurements during angiography	15.30	
J001	Arthrogram	15.30	4
	Biliary duct calculus manipulation etc. – see Z562 on page 107.		
J024	Bronchial brushing–unilateral	63.20	6
J044	–bilateral	94.80	6
J002	Bronchogram–unilateral	19.00	6
J043	–bilateral	28.50	6
J003	Bronchogram with intra-tracheal catheter–unilateral	38.60	6
J042	–bilateral	57.80	6
J050	Carotid or vertebral artery occlusion by detachable balloon–percutaneous	173.50	
J005	Dacrocystogram	23.55	4
J006	Discogram–one disc	54.50	4
J030	–each additional disc	28.10	
J049	Embolization of spinal arteriovenous malformation–percutaneous	247.90	5
J036	Fistula or sinus injection	15.30	
J008	Hysterosalpingogram	31.80	4
J004	Intramammary needling for localization under mammographic control	23.55	
	Intubation of small intestine–see Z540 on page 104		
J009	Laryngogram	19.00	
J010	Lymphangiogram–per side	54.50	
J037	Mammary ductography	23.55	
J011	Myelogram	54.50	4
J038	–with supine views requiring removal and re-introduction of spinal needle, add	15.30	
J020	–with posterior fossa views, add	15.30	
J012	Nephrotomogram		4
J045	Percutaneous antegrade pyelogram	63.20	4
J046	Percutaneous nephrostomy	115.70	4
J041	Percutaneous removal of intravascular foreign bodies	153.00	I.C.
J051	Percutaneous spinal cord puncture for syringogram	53.70	4
J013	Percutaneous trans-hepatic cholangiogram	54.50	4
J015	Peritoneal pneumogram	23.55	4
J016	Pneumoencephalogram	70.20	5
J052	Positive contrast cisternogram	70.20	4
J017	Presacral insufflation	39.70	4

CLINICAL PROCEDURES, ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Code		Specialist	Anæsthetist
J039	Renal cyst puncture	$ 63.20	4
J018	Sialogram	23.55	4
J007	Tomogram		4
J028	Urethrogram, urethrocystogram, or intestinal conduit examination, nephrostogram, cystogram	15.30	
J029	Vasogram	42.15	4

DIAGNOSTIC ULTRASOUND

T and P Columns should be interpreted in the spirit of the first two paragraphs on page 32, but without limiting the performance of these tests to physicians of any one specialty. **Furthermore, the physician must be physically available to approve, modify or intervene in the examination as required or the examination must be completely recorded by video/computer methods and reviewed in its entirety by the physician. No fee (either professional or technical) may be charged if the physician's only involvement is the interpretation of hard copy (films).**

Notes: A-Mode–implies a one-dimensional ultrasonic measurement procedure.

M-Mode–implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.

Scan B-Mode–implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

All ultrasound examinations include a permanent record and interpretative report.

Code	**Head and Neck**	T	P
J100	Echoencephalography-midline, A-mode	$ –	$ 3.75
J122	Brain–complete, B-mode	38.30	22.05
	Echography-ophthalmic (excluding vascular study)		
J102	Quantitative, A-mode	20.10	29.30
J103	B-scan immersion	39.30	38.90
J107	B-scan contact	19.90	19.30
J108	Biometry (Axial length–A-mode)	26.10	19.65
J105	Face and/or neck (excluding vascular study)	38.30	22.05
J106	**Paranasal sinuses, A-mode**	**5.25**	**2.25**
	Heart		
J118	Echocardiography–complete study–1 dimension	28.90	28.90
J120	–2 dimensions (real time)	49.50	45.40
J121	–1 and 2 dimensions at same patient visit	63.60	60.20
J119	–limited study–1 or 2 dimensions for follow up studies–not to be charged in conjunction with pregnancy study	13.70	13.70
J109	Saline study (including venipuncture)	–	9.00
J110	**Cardiac Doppler study in conjunction with complete 1 and 2 dimension echocardiographic study when performed by physician**	**37.50**	**30.00**
	Thorax		
J125	Chest masses, pleural effusion-A & B-mode	39.45	22.70
	Abdomen and Retroperitoneum		
J135	Abdominal scan, complete	39.45	22.70
J128	Abdominal scan, limited study (e.g. gallbladder only, aorta only or follow-up study)	26.00	15.10
	Pelvis		
J159	Pregnancy, complete	39.45	22.70
J162	Pelvic, complete	39.45	22.70
J163	Pelvis or pregnancy, limited study (e.g. fetal age determination, placental localization, I.U.C.D. localization only	26.00	15.10

DIAGNOSTIC ULTRASOUND

Code	Vascular System	T	P
	Extra-cranial vessel assessment (bilateral carotid and/or subclavian and/or vertebral arteries) – Doppler scan or B scan		
J190		$35.80	$20.60
J191	–frequency analysis	35.80	20.60
J192	–frequency analysis with scan	53.70	30.90
	Peripheral artery evaluation **(not to be billed routinely with J190, J191 or J192)**		
J193	–Doppler scan or B scan	17.90	13.65
J194	–frequency analysis	12.00	11.25
J195	–frequency analysis with scan	25.40	21.15
J198	Venous assessment (bilateral–includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manœuvres and permanent record (not chargeable during surgery or during patients' post operative stay in hospital)	6.00	9.20
	Vascular laboratory fees		
J199	Ankle pressure determination–not chargeable during surgery or during the patients' post operative stay in hospital	–	7.20
J200	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings	16.60	20.30
J196	Ankle pressure measurements with exercise and/or quantitative measurements added to the above	6.45	9.60
J197	Penile pressure recordings–two or more pressures	5.60	7.20
	Miscellaneous		
J180	Echography for placement of radiation therapy fields, scan B-mode	28.50	17.55
J182	Extremities–per limb (excluding vascular study)	19.10	11.10
J127	Breast–scan B-mode (per breast)	19.10	11.10
J183	Testicular scan–per testis	19.10	11.10
J149	Ultrasonic guidance of biopsy, aspiration, amniocentesis or drainage procedures (one physician only)	38.30	22.05

PULMONARY FUNCTION STUDIES

Column T – The benefit for testing including supplying of equipment, premises and technical services.

Column P – The benefit for professional services including responsibility for quality control and technician training, interpretation of the results of the tests, and consultation between the physician responsible for the tests and the referring physician concerning the results of the tests.

Notes:
1. The total benefit is obtained by adding columns T and P together.
2. The benefits for J301, J324, J304 and J327 **must be performed with a permanent record and** represent the best of three recorded test results with or without bronchodilator.
3. Vital capacity, J301, and flow volume loop, J304, cannot be claimed at the same time.
4. **Each of the following tests designated by an individual code number is considered to be specific and requires individual ordering.**
5. **Exercise assessment (J315, E450, E451, J316, J317) requires a physician to be in attendance at all times.**
6. **J309 and J310 cannot be claimed at the same time.**

Code		T	P
J301	Vital capacity, FEV $_1$, FEV$_1$/FVC **with or without MMEFR (FEF 25-75) calculation**	$ 7.50	$ 5.60
J324	Repeat J301 after bronchodilator	2.25	2.25
J304	Flow volume loop (FVC, FEV $_1$, FEV$_1$/FVC, $\dot{V}_{50}$, $\dot{V}_{25}$)	15.00	10.70
J327	Repeat J304 after bronchodilator	2.25	2.25
J311	Functional residual capacity by gas dilution method	13.05	11.55
J307	Functional residual capacity by body plethysmography	14.10	11.70
J305	Lung compliance (pressure volume curve of the lung from TLC to FRC)	41.80	35.50
J306	Airways resistance by plethysmography or estimated using esophageal catheter	13.00	10.60
J309	Carbon monoxide diffusing capacity by steady state at rest	8.70	6.60
J310	Carbon monoxide diffusing capacity by single breath method	17.25	11.90
J308	Carbon dioxide ventilatory response	16.05	10.80
J328	Oxygen ventilatory response (physician must be present)	16.05	16.05
J315	Stage I: Graded exercise to maximum tolerance exercise (must include continuous heart rate and ventilation at rest and at each workload)	39.90	26.70
E450	J315 plus J301 or J304 before and/or after exercise, add	10.65	5.40
E451	J315 plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise, add	14.50	16.80
J316	Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO_2, VCO_2, BP, ECG, end tidal and mixed venous CO_2 at rest, 3 levels of exercise and recovery)	105.30	49.35
J317	Stage III: **J316** plus arterial blood gases, pH and bicarbonate or lactate	139.60	83.85
J330	Assessment of exercise induced asthma (workload sufficient to achieve heart rate 85% of predicted maximum; performance of J301, J325 or J304 before exercise and 5-10 minutes post exercise	26.80	16.10
G479	Arterial puncture for blood gas analysis	–	6.75
J319	Blood gas analysis: pH, PO_2, PCO_2, bicarbonate and base excess	9.00	–
J318	Arterialized venous blood sample collection (e.g. ear lobe)	3.00	–
J320	A-a oxygen gradient **requiring** measurement of RQ by sampling mixed expired gas and using alveolar air equation	22.10	8.50
J331	Estimate of shunt (Qs/Qt) breathing pure oxygen	22.10	11.10
J313	Mixed venous PCO_2 by the rebreathing method	9.00	3.00
J323	O_2 saturation by oximeter at rest, **with or without O_2**	8.40	4.20
J332	**– oxygen saturation by oximeter at rest and at exercise**	13.05	6.60
J334	**J332 with supplemental O_2**	**19.50**	**9.90**
J322	Standard O_2 consumption and CO_2 production	21.50	5.60
J333	**Non-specific bronchial provocative test** (histamine, methylcholine, **thermal challenge**)	31.05	22.80
J335	Antigen challenge test	41.60	22.80
J339	Sleep apnea (overnight) study with **continuous** monitoring of oxygen saturation and ventilation – to include physician attendance at set up, monitoring and interpretation (special visit premiums not chargeable)	–	99.75
J336	Interpretation of J339 only	–	37.10
J337	Same as J339 plus additional monitoring such as to allow the staging of sleep, e.g., E.E.G., E.O.G., add to J339 when both performed	–	37.10
J338	Interpretation of J337 only, add to J336 when both performed	–	15.45

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code With a few exceptions specifically indicated below, the listed procedural benefits are for the procedure(s) alone. Consultations or visit benefits when such services are rendered, may be claimed in addition to the procedural benefits.

G700 When a procedure(s) is the sole reason for a visit, add **$ 3.90** basic fee per visit for those procedures marked (+) regardless of the number of procedures carried out during that visit. However, if the patient visit is to a physician's office or a diagnostic facility controlled directly or indirectly by a physician who has examined (or is about to examine the patient) and referred the patient to such a diagnostic facility, no basic fee should be claimed under these circumstances.

Note: G700 it not payable to a hospital department.

Fee Schedule Interpretations

1. Urinalysis and other laboratory tests listed on page 48, apply when these services are performed by a physician in his office with or without an associated consultation or visit. The same tests listed in the Laboratory Medicine Section of the Schedule apply to licensed laboratories.

2. Some fees for Diagnostic and Therapeutic Procedures have the technical and professional components listed separately. The technical component includes the salaries of support staff, equipment depreciation or lease costs, supplies and costs associated with the preparation of a written report. The professional component includes the clinical supervision of the diagnostic facility, interpretation of the test results and a written report. When only one fee is listed for a service, it represents the professional component only.

3. The Preamble applicable to Surgical Procedures (pages 55-57) also applies, where appropriate, to Diagnostic and Therapeutic Procedures.

ALLERGY

Note: If a patient presents for an allergy injection and has an acute infectious condition, albeit of the respiratory system, or some other unrelated condition which would have otherwise required a separate office visit, the physician is entitled to charge the appropriate assessment fee as well as the injection fee. If a patient requires a brief assessment of his allergic condition as well as the allergy injection, the physician should bill the injection and basic fees.

Code		Procedural Fee	Anaesthetist
+G200	Acute desensitization, e.g. ATS, penicillin	$ 6.40	
+G201	Direct nasal tests, $1.10 each, maximum	3.30	
+G202	Hyposensitization, including assessment and supervision (one or more injections)	2.80	
G212	**–when sole reason for visit (G700 plus G202)**	**6.70**	
G205	Insect venom desensitization (immunotherapy)–per injection (to a maximum of 5 per patient per diem. In addition to G205, after the initial major assessment, a minor **or partial** assessment may be claimed once per day if rendered	9.50	
+G203	Ophthalmic tests–direct, $1.10 each, maximum	3.30	
+G204	–quantitative	9.00	
G206	Patch test, $1.10 each, maximum of 35 per year	38.50	
G198	maximum of 50 per year for industrial or occupational dermatoses	55.00	
+G207	Bronchial provocative testing–per session (limit of 6 sessions per patient)	10.30	
G209	Skin tests provided in physician's office or hospital including physician interpretation,60¢ each–technical component, maximum	30.00	
G197	10¢ each–professional component, maximum	5.00	
G199	Insect venom skin testing provided in physician's office or hospital including physician interpretation, $.91 each, maximum	27.30	
G195	Local anæsthetic hypersensitivity skin test, $.77 each, maximum of 25 per year	19.25	
G196	Penicillin hypersensitivity skin test, $.77 each, maximum of 15 per year	11.55	

ANAESTHESIA

Code		Procedural Fee	Anaesthetist
G260	**Examination Under Anæsthesia**–when sole procedure performed not otherwise listed in the schedule. with or without intubation (diagnosis required)	37.50	4

CARDIOVASCULAR

Vascular Cannulation

Code		Procedural Fee	Anaesthetist
G479	Arterial puncture	6.75	
G268	Cannulation of artery or central vein e.g. for pressure measurements or for feeding line, including cut down as necessary	22.90	
G309	Umbilical artery catheterization (including obtaining of blood sample)	33.20	
+G480	Venipuncture–infant	6.80	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR–Cont'd.	Procedural Fee	Anaesthetist
+G482	–child	$ 4.60	
+G489	–adolescent or adult	1.65	
+G483	Therapeutic venisection	7.05	
G282	Umbilical vein catheterization (including obtaining of blood sample)	14.50	
G287	Insertion of Swan-Ganz catheter (not included in anæsthetic, respiratory or critical care benefits)	118.90	4
G304	–when dye dilution densitometry done in addition, add **to a max. of 3 times**	37.50	
G398	Insertion of permanent feeding line e.g. Hickman or Broviac catheter	99.40	4
G399	Surgical removal of Hickman or Broviac catheter	28.90	4
G271	Anticoagulant supervision–long term, telephone advice–per month	7.70	
	Blood Transfusions:		
G279	Indirect transfusion	13.65	
G275	Exchange transfusion (procedure only)	150.00	
	Assistant at exchange transfusion (see Preamble–page x, item 36(g))		
G280	Intra-uterine fœtal transfusion–initial or subsequent	136.50	
G276	Donor cell pheresis (platelets or leukocytes)	11.25	
	Therapeutic plasma exchange		
G277	Initial and repeat, to a maximum of 5 per year, each	55.40	
G278	–more than 5 per year, each	27.70	
G272	Manual plasmapheresis	I.C.	
	Cardioversion:		
G285	Cardioversion (**electrical**)–limit of three sessions per patient, per day	45.00	5
	Cardiac Catheterization When more than one procedure is carried out at one sitting, the additional procedures are to be charged at 50% of the listed benefits.		
	Hemodynamic/Flow/Metabolic Studies		
G290	Right heart–pressures only	112.50	5
G291	Left heart–retrograde aortic	132.40	5
G292	–transeptal	187.50	5
G296	Dye dilution densitometry and/or thermal dilution studies –benefit covers all studies on same day	75.00	
	Note: When G296 is done in addition to G287, it may be claimed at 50% only. Use code G304 instead.		
G299	Oxymetry	75.00	
G289	Fick determination	75.00	
G300	Metabolic studies e.g. coronary sinus lactate and pyruvate determinations	75.00	
G301	Exercise studies during catheterization	82.50	
G306	Isotope studies during cardiac catheterization	75.00	
G305	Intracardiac phonocardiography	82.50	
	Angiography		
G297	Angiograms (any number of injections)	75.00	
G293	Selective coronary catherization–both arteries	183.75	5
G263	–with drug interventional studies, add	66.40	
G265	Transluminal coronary angioplasty, including angiography with or without pressure measurements, one or more sites or vessels	273.75	5
	Electrophysiology/Pacing		
G286	Endocardial mapping studies (does not include G267 or G294)	187.50	5
G298	Intracardiac electrocardiography and/or arterial pacing	75.00	
G267	HIS bundle ECG	124.90	
G266	Electrophysiologic studies (programmed stimulation drug intervention), with or without HIS Bundle ECG	168.75	
G294	Insertion of temporary endocardial electrode	112.50	5
G254	Repositioning of temporary endocardial electrode	46.90	5
G303	Insertion of transthoracic pacemaker	37.50	
	Endomyocardial Biopsy		
G288	Endomyocardial biopsy–transvascular, right or left	124.90	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR—Cont'd.	Procedural Fee	Anaesthetist
	Electrocardiography – professional component must include pertinent written interpretation		
G313	E.C.G.—professional component—practice in general	$ 5.25	
G318	—specialist	7.10	
+ G310	—technical component	5.25	
	Before and after exercise (Master's criteria) includes complete resting tracing and multiple leads taken immediately and 3 and 6 minutes post exercise.		
G314	—technical component	7.90	
G334	—professional component	7.90	
	Maximal stress E.C.G (exhaustion, symptoms, or E.C.G changes) or submaximal stress E.C.G. (to target heart rate for patient) by a standard technique—with treadmill or ergometer and oscilloscopic continuous monitoring including E.C.G's taken during the procedure and resting E.C.G's before and after the procedure—physician must be in attendance at all times. The professional component includes the necessary clinical assessment immediately prior to testing.		
G315	—technical component	26.25	
G319	—professional component	39.75	
G316	Vector—technical component	13.50	
G335	—professional component	7.35	
	Continuous ECG Monitoring e.g. Holter		
	Level 1—Requires a recorder capable of recording **or analyzing** all beats and transmitting this information to a scanner which is capable of analyzing **or** printing every beat and also performing **a** trend analysis on the 12 or 24 hour tape **period.**		
	Level 2—Requires a recorder capable of recording only a portion of each minute, or a predetermined time period after an abnormal complex is sensed. The scanner of this recorder is capable of analyzing this tape and printing out all beats in the predetermined time period analyzing—the ST segment, heart rate and ventricular premature beat frequency.		
	Level 3—Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adapter that feeds the information through the standard E.C.G. machine.		
G650	Level 1—professional component	35.10	
G651	—technical component—recording	19.10	
G652	—scanning	26.25	
G653	Level 2—professional component	25.50	
G654	—technical component—recording	18.60	
G655	—scanning	12.75	
G656	Level 3—professional component	17.00	
G657	—technical component—recording	12.75	
G658	—scanning	8.50	
	Interpretation of telephone transmitted E.C.G. rhythm strip		
G320	—professional component (must include pertinent written interpretation) .	3.10	
G311	—technical component	1.50	
	Single chamber reprogramming including electrocardiography		
G283	—professional component	7.00	
G284	—technical component	7.00	
	Dual chamber reprogramming including electrocardiography		
G180	—professional component	10.40	
G181	—technical component	9.30	
	Pacemaker pulse wave analysis including electrocardiography		
G307	—professional component	7.00	
G308	—technical component	7.00	
	Non Invasive Cardiography:		
	Note: When more than one procedure of items marked (*) are performed at one sitting, the major procedure is to be claimed at full benefit and the remainder at 50% of the listed benefit(s).		
	*Phonocardiogram—multiple channel (not less than 3 channels)		
G504	—professional component	12.75	
G505	—technical component	30.90	
G506	(with pharmacologic intervention), add	6.40	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**CARDIOVASCULAR**–Cont'd.	Procedural Fee	Anaesthetist
G507	*Apex cardiogram–professional component	$ 7.70	
G508	–technical component	7.70	
	Note: Fees for apex cardiography and E.C.G. may be charged when both services are rendered.		
	Echocardiography – see Diagnostic Ultrasound.		
	Blood Flow Study (Doppler or other)–uni or bilateral		
	*Phlebography and/or carotid pulse tracing (with systolic time intervals)		
G518	–professional component	8.25	
G519	–technical component	8.25	
G502	Carotid phonoangiography–professional component	7.70	
G503	Oculoplethysmography–professional component	7.70	
G120	Impedance plethysmography–professional component	5.00	
G121	–technical component	9.90	
	Peripheral Arterial and Venous Systems – see listings under Diagnostic Ultrasound on pages 38, 39		
	CRITICAL CARE		
	Life Threatening Emergency Situation–Resuscitation in emergency situation (cardiac arrest, massive injury, cardio-respiratory failure, resuscitation of newborn, severe shock, coma) includes immediate crisis related examination and usual resuscitative measures and to include as required, defibrillation, cardioversion, cut downs, intravenous lines, arterial and/or venous catheters, pressure infusion sets and pharmacological agents, urinary catheters, C.V.P. lines, blood gases, nasogastric tubes with or without lavage, endotracheal intubation and tracheal toilet.		
G521	Detention per physician–first ¼ hour	61.90	
G522	–after first ¼ hour (per ¼ hour or major part thereof)	20.40	
	Other Resuscitation		
G395	Detention per physician–first ¼ hour	30.90	
G391	–after first ¼ hour (per ¼ hour or major part thereof)	15.45	
	Consultation or assessments rendered before or after provision of critical care may be claimed on a fee for service basis.		
	Hyperbaric Therapy (per dive)		
G800	Physician in chamber with patient(s)–per dive, first ¼ hour	41.30	
G801	–after first ¼ hour (per ¼ hour or major part thereof)	20.70	
G802	–after 2 hours in chamber (per ¼ hour or major part thereof)	41.30	
	Physician not in chamber with patient(s)–per dive, claim on the basis of Other Resuscitation (G395 and G391).		
	Consultation(s) or assessment(s) and special visit premium(s) may be claimed on a per patient basis when these services are rendered.		
	Note: Hyperbaric therapy is not a benefit of OHIP for treatment of some conditions. Please refer to OHIP District Medical Consultant for qualifying diagnosis.		
G211	**Endotracheal intubation for resuscitation** (not to be claimed when followed by a surgical procedure)	26.25	
G210	**Hypothermia** (therapeutic) induction and management	140.60	
	Respiratory Care–includes examinations of the patient and includes (as required), intravenous lines, pressure infusion sets and pharmaceutical agents, insertion of arterial, C.V.P. or urinary catheters, securing and interpretation of blood gases, nasogastric tubes, endotracheal intubation with or without artificial ventilation, tracheal toilet, use of an artificial ventilator and all necessary measures for its supervision.		
	Physician-in-Charge		
G405	–1st day	139.10	
G406	–2nd to 5th days (inclusive) per diem	62.60	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CRITICAL CARE–Cont'd.	Procedural Fee	Anaesthetist
G407	–6th to 28th days (inclusive) per diem	$ 55.50	
G408	–29th day onwards per diem	$ 34.90	

If patient has been discharged from Unit more than 48 hours and is re-admitted to Unit, 1st day rate applies again on day of re-admission.

The fees under Physician-in-Charge apply per patient treated, i.e., while the physician-in-charge may change during the course of treatment, the fee formula as set out should be charged by the physicians involved as if there was only one physician-in-charge during the treatment program.

The appropriate consultation, procedure and visit benefit shall apply after stopping artificial respiration or special care.

Other physicians apart from those providing Respiratory Care may charge the appropriate consultation, visit and procedure fees.

Neonatal Intensive Care

Level A: Full life support including invasive monitoring, ventilatory support, and parenteral alimentation (all modalities)

Code		Procedural Fee	Anaesthetist
G600	–1st day	232.50	
G601	–2nd to 10th days (inclusive) per diem	115.50	
G602	–11th day onwards, per diem	57.75	

Level B: Intensive care including full monitoring both invasive and non-invasive, oxygen administration and intravenous therapy, but without ventilatory support

Code		Procedural Fee	Anaesthetist
G610	–1st day	150.00	
G611	–2nd day onwards, per diem	42.40	

Level C: Intermediate care including oxygen administration, non-invasive monitoring and gavage feeding

Code		Procedural Fee	Anaesthetist
G620	–1st day	100.50	
G621	–2nd day onwards, per diem	21.00	

The above benefits include the initial consultation or assessment and subsequent examinations of the patient and, as required, insertion of arterial, venous, C.V.P. or urinary catheters, intravenous lines, interpreting of blood gases, nasogastric tubes, pressure infusion sets and pharmaceutical agents, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support.

These are team fees which apply to neonatologists/pædiatricians/anæsthetists providing complete care. If ventilator care only is provided by anæsthetist(s), the above listings do not apply. Claims should then be made under Respiratory Care (G405, etc.) with Neonatology Pædiatric components billed on a fee for service basis.

If infant has been transferred from one level to another in either direction, up or down, second day benefits apply.

Regular visit and procedure benefits will apply the day following termination of Neonatal Intensive Care.

If patient has been discharged from Unit more than 48 hours and is re-admitted to Unit, 1st day rate applies again on day of re-admission.

The appropriate consultation, procedure and visit benefits shall apply after stopping artificial respiration or special care.

Intensive Care Monitoring

This category excludes Cardio-Pulmonary Resuscitation and Respiratory Care and should be claimed on the basis of the appropriate consultation, procedure and visits benefit.

DIALYSIS: team benefits, to include listed items. (This does not include preliminary investigation of the case.)

Hæmodialysis (to include hæmofiltration, hæmoperfusion)

Code		Procedural Fee	Anaesthetist
R849	Initial and acute (to include surgical components)	637.50	6
R850	Insertion of cannula (to be included in the $637.50 initial)	228.75	6
G325	Medical component (to be included in the $637.50 initial)	408.75	
G323	Acute, repeat (maximum of 3)	206.25	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**DIALYSIS**–Cont'd.	Procedural Fee	Anaesthetist
G326	Chronic each	$ 47.90	
G327	Revision of cannula–single	75.00	4
G328	–both	111.00	4
G329	De-clotting of cannula	68.25	
R843	Removal of cannula or A.V. shunt	59.25	4
R827	Creation of A.V. fistula–see listing on page 97	262.50	6
R841	Obliteration of A.V. fistula	60.00	4
R851	By-pass graft for hæmodialysis–synthetic	289.50	7
R840	–autogenous vein	309.00	7
R833	Ligation or removal of by-pass graft	60.00	4
G324	Insertion of subclavian catheter for hæmodialysis	68.25	
G336	–Revision	11.25	
	Peritoneal dialysis		
G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	144.75	
G331	Repeat acute (up to 48 hours)–maximum of 3	132.00	
G332	Chronic (up to 48 hours)–maximum of $136.50 per week	68.25	
R852	Insertion of peritoneal cannula by laparotomy	136.50	6
R853	Insertion of Tenchkov type peritoneal catheter–chronic–by trocar	68.25	4
R854	Removal of Tenchkov type peritoneal catheter	37.10	
	Home/self-care dialysis–services rendered by physician		
G333	**Hemodialysis and peritoneal dialysis (intermittent peritoneal dialysis and continuous ambulatory peritoneal dialysis)–includes routine clinic visits (system/drug/dialysis technique/blood work review and physical examination), counselling/psychotherapy of patients and relatives and supervised dialysis when required, per patient, per week**	22.05	
	When physicians are required to make emergency visits to see patients on any form of home/self-care dialysis the appropriate visits and premiums are benefits. When the patient requires hospitalization, the appropriate fees for daily care and in-hospital dialysis are benefits instead of G333.		
	ENDOCRINOLOGY AND METABOLISM		
+G493	ACTH test–single or multiple, per injection	4.65	
+G337	Antidiuretic hormone response test including the 8 hour water deprivation test	12.40	
+G338	Clonidine suppression test (for the investigation of pheochromocytoma)–with physician present–includes venipunctures	18.15	
	Glucagon test		
+G494	(Type A) for carbohydrate response	7.50	
+G495	(Type B) for hypertension, pheochromocytoma and insulinoma provocative test (including cold pressor test)	30.90	
G358	Growth hormone exercise stimulation test with physician present (includes venipunctures)	18.15	
+G340	Histamine test to include a control cold pressor test	33.10	
+G341	Hypertonic saline infusion test	12.40	
+G342	Implantation of hormone pellets	22.70	
+G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination	36.30	
+G498	Intravenous glucose tolerance test	7.50	
+G499	Intravenous tolbutamide test	36.30	
+G513	Pentagastrin stimulation for calcitonin	12.40	
+G344	Phentolamine test	30.90	
+G501	TRH or LHRH test, per injection	4.65	
+G490	Saralasin test	30.90	
	GASTROENTEROLOGY		
G349	Oesophageal tamponade (Blakemore bag)–insertion	33.10	
	Oesophageal motility study(ies) with manometry		
G350	–standard, with physician in continuous attendance	65.60	
G343	–interpretation only	14.50	
G353	Oesophageal acid perfusion test **and/or provocative drug testing** with physician in continuous attendance	24.75	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural Fee	Anaesthetist
	GASTROENTEROLOGY–Cont'd.		
G252	–interpretation only	$ 7.90	
	Oesophageal pH study for reflux, **with installation of acid**		
G251	–standard, with physician in continuous attendance	24.75	
G351	–with 24 hour monitoring	28.95	
G346	–tracing interpretation only	14.50	
	Gastric lavage		
+G355	(a) diagnostic	7.00	
G356	(b) therapeutic–with or without ice water lavage	24.75	
+G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin)–procedure and supervision	13.65	
G352	Biliary tract provocative test with cholecystokinin	7.00	
G354	Anal-rectal manometry with physician in continuous attendance	33.10	
G253	–interpretation only	7.80	
	GYNAECOLOGY		
G367	Artificial insemination	18.60	
G363	Cervical mucus penetration test	12.75	
G361	Endometrial flushing	12.75	
+G364	Huhner's test	12.75	
G374	Insufflation and endometrial biopsy	23.40	
G378	Insertion of intra-uterine contraceptive device	15.45	
+G365	Papanicolaou smear	3.40	
	(The Papanicolaou smear is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), partial assessment, annual health, or routine post-natal visit when a pelvic examination is a normal part of the foregoing services.)		
	Vaginal insufflation	visit fees	
	INJECTIONS OR INFUSIONS		
+G369	**B.C.G. inoculation,** following tuberculin tests	3.90	
	Note: Multiple B.C.G. inoculations used for treatment of carcinoma are to be considered experimental and no claims should be made for this service.		
+G370	**Bursa, joint, ganglion or tendon sheath and/or** aspiration	14.60	
G371	(each additional site or area, $7.30–maximum $36.50 per visit)		
	Note: G370, G371 – not allowed in addition to surgical benefits when performed at time of surgery.		
	Chemonucleolysis		
	Lateral discography		
G389	–lumbo sacral disc–as first disc	87.00	
G390	–any other disc–as first disc	45.40	
G386	–second and subsequent discs each	22.70	
	Injection for chemonucleolysis		
G392	–initial injection	37.50	
G393	–any subsequent injection at other levels, each	18.75	
G396	**Injections of extensive keloids**	18.15	
G397	–under general anæsthesia	33.10	
	Intramuscular, subcutaneous or intradermal including interpretation		
	–with visit,		
G372	–each injection	1.65	
	Intramuscular, subcutaneous or intradermal including interpretation		
	–sole reason,		
G373	–first injection	3.90	
G372	–each additional injection	1.65	
	Intralesional infiltration		
+G375	–one or two lesions	6.60	
+G377	–3 or more lesions	9.75	
G383	–extensive	I.C.	
G462	**Administration of oral polio vaccine**–if only service rendered	1.20	
G384	**Infiltration of tissues for trigger point**	6.60	
G385	–more than one site add	3.30	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**INJECTIONS OR INFUSIONS**–Cont'd.	Procedural Fee	Anaesthetist
	Intravenous		
+G376	Infant	$ 7.50	
+G379	Child or adult	4.60	
	Notes (1) G376 or G379 apply to cryoprecipitate infusion. **(2) G376, G379 may not be claimed with G279.** **(3) Except for G381, G281, injections into established I.V. apparatus may not be claimed.**		
+G380	Cut down including cannulation as necessary	19.90	
	Chemotherapy (marrow suppressant) – with each injection initiated by a physician by intravenous infusion for treatment of malignant or auto-immune disease		
+G381	–single injection **(for agents other than adriamycin, cisplatin, bleomycin or high dose methotrexate)**	10.10	
G281	–each additional injection **(other than above drugs)**	5.10	
	Chemotherapy and patient assessment provided by physician in hospital based clinics or to in-patients (the following benefits include patient assessment for a 24 hour period, drug administration and establishment of intravenous to a maximum of one fee claimed, every three weeks)		
G339	**–single agent intravenous chemotherapy i.e. adriamycin, cisplatin or bleomycin**	**33.75**	
G345	**–multiple agent intravenous chemotherapy including at least one of either adriamycin, cisplatin or bleomycin**	**45.00**	
G359	**–special single agent chemotherapy utilizing either high-dose methotrexate with folinic acid rescue – methotrexate given in a dose of greater than 1 g/m^2 or high dose cisplatin greater than 75 mg/m^2 given concurrently with hydration and osmotic diuresis**	**63.75**	
G382	Supervision of chemotherapy (marrow suppressant) for malignant or auto-immune disease by telephone–monthly	8.30	
	Varicose veins (maximum per visit–$14.90)		
+G387	–single injection	7.50	
G388	–multiple (unilateral or bilateral) each additional	3.70	
G536	**Compression sclerotherapy (includes multiple injections, compression bandaging and one post injection visit)**	**56.25**	
G537	**Repeat compression sclerotherapy**	**18.75**	
G510	**Management of parenteral alimentation–physician in charge**–up to twelve weeks ... per visit	13.10	
G511	from thirteenth to twenty-sixth week (not to exceed $39.30 per week) ... per visit	13.10	
G512	from twenty-sixth week onwards (not to exceed $ 78.60 per month) ... per visit	13.10	

LABORATORY MEDICINE IN PRIVATE OFFICE

The following benefits apply to physicians who perform these particular tests in their own offices. The L.M.S. schedule for Laboratory Medicine on pages 15-27 for these particular tests applies to licensed laboratories.

G001	Cholestreol, total	4.10	
G002	Glucose, quantitative or semi-quantitative – **see Laboratory Medicine Preamble, page 15, para. 4.**	1.50	
G481	Haemoglobin screen and/or haematocrit (any method or instrument)	1.00	
G003	Lactic dehydrogenase (L.D.H.) total	3.00	
G004	Occult blood	1.20	
G005	Pregnancy test	3.10	
G006	SGOT	3.00	
G007	Urea nitrogen (B.U.N.)	1.80	
G008	Uric acid	1.80	
G009	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of S.G., pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)	3.60	
G010	–one or more parts of above without microscopy	1.60	
G011	Fungus culture including KOH preparation and smear	10.20	
G012	Wet preparation (for fungus, trichomonas, parasites)	1.50	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	NEPHROLOGY	Procedural Fee	Anaesthetist
G411	Nephrological management of donor procurement–includes management of the neurologically "dead" donor on life support systems, assessment of renal functions pre-nephrectomy, pre-nephrectomy immunotherapy, assessment as to potential recipients to be called in, etc.	$140.60	
G347	Renal perfusion with hypothermia for organ transplantation	70.30	
G348	Renal preservation with continuous machine perfusion	70.30	
G412	Nephrological component of transplantation, including complete patient care for first 48 hours following transplantation	337.50	
	NERVE BLOCKS–not to be charged when used as local anæsthesia for surgical procedures		
G214	Brachial plexus	39.70	
G215	Coeliac ganglion	61.20	
G239	Differential intrathecal spinal block	92.70	
G216	Epidural block	54.50	
G245	Epidural or intrathecal injection of sclerosing solution	119.70	
G243	Femoral nerve–unilateral	39.70	
G244	–bilateral	59.50	
G246	Introduction of epidural catheter for relief of pain: institution	56.25	
G247	– hospital visits for each **additional** visit rendered (to a maximum of 4 visits per day) See also Preamble para B 37(x)	visit fees	
G218	Ilioinguinal and iliohypogastric nerves	39.70	
G219	Infraorbital	24.80	
G220	Intercostal nerve	24.80	
G221	–for each additional one, add	12.40	
G222	Intrathecal spinal	54.50	
G225	Mental branch of mandibular nerve	24.80	
G250	Maxillary or mandibular division of trigeminal nerve	54.50	
G241	Obturator nerve–unilateral	39.70	
G242	–bilateral	59.50	
G227	Other cranial nerve block	61.20	
G228	Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves	39.70	
G123	–for each additional one, add (to a maximum total of $119.30)	19.90	
G229	Pudendal–unilateral	39.70	
G240	–bilateral	59.50	
G422	Retrobulbar injection (not to be claimed when used as a local anæsthesia)	24.80	
G230	Sciatic nerve	39.70	
G226	–bilateral	59.50	
G248	**Single shot caudal block done in conjunction with anaesthesia**	**11.25**	
	Somatic or peripheral nerves not specifically listed		
G231	–one nerve or site	24.80	
G223	–additional nerve(s) or site(s), add	12.40	
G232	Spleno-palatine ganglion	39.70	
G233	Splanchnic	39.70	
G234	Stellate ganglion	39.70	
G256	Superior laryngeal nerve	24.80	
G235	Supraorbital	24.80	
G236	Sympathetic block(s) (lumbar or thoracic)	39.70	
G237	–bilateral	59.50	
G238	Transverse scapular nerve	39.70	
G217	Trigeminal ganglion	61.20	
E958	When alcohol or other sclerosing solutions are used, add 50% to the appropriate nerve block fees as listed above with the exception of fee codes G245 and G246.		
G273	Epidural injection of adrenal steroid or autologous blood	53.70	
G274	–post laminectomy into operative site	65.25	
Z804	Lumbar puncture	29.70	
Z805	–with instillation of medication	39.70	
G410	Amytal test (Wada)–bilateral-supervision and coordination of tests	49.60	
G413	Electrocorticogram–supervision and interpretation	123.75	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	NEUROLOGY–Cont'd.	Procedural Fee	Anaesthetist
G419	Tensilon test	$ 14.50	
G551	Katzman test (subarachnoid infusion test) including lumbar punctures	123.75	
	Electroencephalography		
+ G414	Technical component	16.50	
G415	Professional component	16.10	
G416	With activating or sleep inducing drugs and/or sleep deprivation, add	11.60	
G417	Inserting subtemporal needle electrodes, add	11.60	
G418	Attendance and supervision of E.E.G. during major surgery	115.90	
G544	Polygraphic recording of three parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.), add per item (to a maximum of $19.80)	6.60	
G545	Videotape recording of clinical signs in association with spontaneous EEG, add to routine fees, per ¼ hr. (maximum of 1 hour)	10.70	
G546	Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add to routine fees	22.30	
G547	Simple average evoked potential studies with one sensory modality of stimulation	17.40	
G548	Complex evoked potential studies involving several sensory modalities, multiple threshold determinations, of more than four simultaneous channels of recording, not completely under supervision	45.45	
G549	Complex evoked potential studies performed completely under direct professional supervision	91.10	
G550	Overnight sleep recording–complete interpretation with sleep staging	66.15	
	OPHTHALMOLOGY		
G424	Contact lens fitting (with follow-up for 3 months) See Append. A	133.50	
G423	One eye only, when the other eye has been previously fitted by the same physician (with follow-up for 3 months)	68.60	
G463	Hydrophilic "Bandage" lens fitting	68.60	
G438	Colour vision detailed assessment (not to be claimed for screening tests such as Ishihara, HRR and University etc.)	18.60	
G437	Dark adaptation curve (Goldmann adaptometer or equivalent)	26.25	
G453	Electro-oculogram–interpretation fee	15.00	
+ G439	Electro-retinography with report	36.30	
+ G425	Fluorescein angiography	36.30	
+ G444	Fluoroscein angioscopy	10.50	
G426	Glaucoma provocative tests, including water drinking tests	22.00	
G428	Hess screen examination	7.35	
G427	Ophthalmodynamometry	7.35	
	Radioactive phosphorus examination		
G429	–anterior approach	32.40	
G430	–posterior approach	65.60	
G421	Subconjunctival or sub-Tenons capsule injection	12.20	
+ G435	Tonometry (Not to be claimed if done in conjunction with an ophthalmological consultation or specific assessment.)	3.90	
G433	Tonography (to include tonometry) with or without water	15.00	
G436	Visual fields – kinetic (with permanent record)	7.35	
G432	Visual fields – static perimetry	22.00	
G464	Visual evoked response	18.60	
	OTOLARYNGOLOGY		
+ G420	Ear syringing or curetting (not claimed with Z907)–uni or bilateral	3.70	
	Diagnostic Hearing Tests (not applicable to fixed level screening audiometry)		
	Pure tone thresholds audiometry with or without bone conduction		
G440	**–technical component**	**6.80**	
G525	**–professional component**	**4.30**	
	Pure tone thresholds audiometry (with or without bone conduction) and speech reception thresholds and/or speech discrimination scores		
G441	**–technical component**	**9.20**	
G526	**–professional component**	**9.00**	
G442	**Impedance audiometry–technical component**	**2.25**	
+ G529	**–professional component**	**1.50**	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	OTOLARYNGOLOGY–Cont'd.	
	Advanced testing e.g. recruitment, tests of malingering central tests and stapedial reflex decay tests and/or compliance measurement–per test (maximum 3 tests)–not to be billed with G442 and G529	
G443	–technical component	$ 6.45
G530	–professional component	4.50
	Hearing aid evaluation and/or fitting of tinnitus masker (does not include G526 and G441)	
G447	–technical component	23.40
+ G531	–professional component	9.40
	Hearing aid re-evaluation and/or re-fitting of tinnitus masker (does not include G526 and G441)	
G445	–technical component	11.70
+ G446	–professional component	4.70
G811	Cortical evoked audiometry–technical component	24.10
G812	–professional component	8.00
	Cortical evoked audiometry, multiple frequency, (minimum of 4 frequencies in each ear)–as required by W.C.B.	
N.C.	–technical component	N.A.B.
N.C.	–professional component	N.A.B.
G813	Brainstem evoked audiometry–technical component	24.10
G814	–professional component	11.60
	Electrocochleography (per ear)–to include myringotomy if performed	
G815	–technical component	24.10
G816	–professional component	77.25
	Diagnostic Balance Tests	
+ G449	Caloric testing without ENG–professional component	5.25
G104	Positional testing with ENG–technical component	15.00
G105	–professional component	13.50
G451	Caloric testing with ENG–technical component	15.00
+ G533	–professional component	13.50
G454	Stroboscopy–professional component	12.50
G191	Optokinetic tests–professional component	9.00
G108	Computerized rotation tests–professional component	15.00
	Diagnostic Taste Tests	
	Electrogustometry or conventional taste tests	
+ G452	–professional component	10.50
	PHYSICAL MEDICINE	
	Electromyography and nerve conduction studies	
	When patients are referred directly to EMG facilities solely for testing, consultation and visit fees are not benefits in addition to the following fees:	
	Schedule A–Complete procedure i.e. conduction studies on two or more nerves involved in the disease process along with EMG studies of multiple muscles and/or detailed studies of neuromuscular transmission. It also includes study of normal nerves and/or opposite side for comparison.	
G456	–professional component–when physician performs EMG, performs and/or supervises nerve conduction studies and interprets results	72.75
G459	–interpretation only	16.10
G455	–technical component	15.00
	Schedule B–Limited or repeat procedure i.e. conduction studies on a single nerve (motor and sensory conduction) along with limited EMG studies of the involved muscle(s).	
G457	–professional component–when physician performs EMG, performs and/or supervises nerve conduction studies and interprets results	51.75
G469	–interpretation only	16.10
G466	–technical component	11.25
+ G460	Strength duration and chronaxie–major	6.20
+ G461	–minor	3.50
	Therapeutic Procedures	
+ G465	Manipulation–major joint(s) or spine–one or more joints (under general anæsthesia, see Surgical Procedures)	10.10

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**PHYSICAL MEDICINE AND REHABILITATION**–Cont'd.		
+G467	**Miscellaneous therapeutic procedures – as listed below**	**$ 6.00**	
	Notes: (1) May be claimed by a physician for physiotherapy procedures performed by an appropriately trained paramedical under that physician's direct supervision. **(2) Only one G467 may be claimed per patient visit.** **(3) Not allowed to hospital inpatient, outpatient or approved physiotherapy facility.**		
	Superficial thermal therapy–radiant, hot pack, whirlpool, parrafin bath, or ice.		
	Deep heat–short wave diathermy, microwave diathermy or ultrasound.		
	Light (ultraviolet)–general or local application.		
	P.U.V.A.		
	Electrotherapy–Galvanic, Faradic, and sinusoidal currents, iontophoresis, transcutaneous nerve stimulation for relief of pain.		
	Hydrotherapy–local (arm or leg) and general (Hubbard) for body immersion; therapeutic pool for under water exercise.		
	Mechanotherapy–massage, mechanical device–traction, pulleys and weights, treadles, stationary bicycles, shoulder wheels.		
	Therapeutic exercise (physiotherapy, physician's own patients).		
	Location and injection of peripheral motor nerves for reduction of spasticity including electrodiagnosis of motor point:		
G485	Major nerve and/or branches	33.20	
G486	Additional major nerve and/or branches	20.70	
	Repeat procedure within one month		
G487	–major nerve	20.70	
G488	–additional major nerve	13.65	
N.C.	**Acupuncture:** i.e., including insertion of needle(s) into specifically selected point(s) combined with manual, electrical or thermal stimulation of the needle(s) for the management of pain, performed by a physician	N.A.B.	
	PSYCHIATRY		
G471	**Electroconvulsive therapy** (E.C.T.) cerebral-single or multiple	22.50	2
	TELERADIOTHERAPY		
+G472	Minor teleradiotherapy–X-Ray, 150 K.V.P. or less–charge per treatment visit	7.65	
	Note: For the first minor teleradiotherapy procedure rendered to a patient, the physician may charge the appropriate consultation or assessment fee in addition to the procedural fee(s). On subsequent visits, only the minor teleradiotherapy plus G700 should be claimed unless additional procedures have been performed or unless there has been a complication or change to a totally unrelated diagnosis. In the first exception, the minor teleradiotherapy plus the benefits for additional procedures may be claimed. In the second exception, the appropriate assessment and minor teleradiotherapy benefits may be claimed.		
	THERMOGRAPHY–one or more areas		
G491	Technical component	12.40	
G492	Professional component	6.20	
	UROLOGY		
G484	Cystometrogram with selective sacral nerve block studies	41.30	
+G475	Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including interpretation with or without use of EMG including interpretation	13.90	
G193	Complete multichannel urodynamic assessment–pressure-flow studies, urethral pressure monitoring, with or without fluoroscopic cystourethrography	19.30	
G194	–with EMG, add to G193	6.20	
+G474	–urethral pressure profile alone including interpretation	6.40	
G477	–interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel)	3.90	
+G476	Prostatic massage	3.90	

OBSTETRICS

1. Obstetrical care is divided into its components. A prenatal major assessment when performed may be claimed; it shall comprise a full history, an inquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient. All other prenatal visits shall comprise the necessary history and inquiry, examination, appropriate record, pregnancy related counselling and advice to the patient. Normal (uncomplicated) prenatal care includes a prenatal general assessment visit, then monthly visits to 32 weeks, followed by visits every 2nd week to 36 weeks, then weekly visits until delivery. However, complicated pregnancies may require additional visits. Labour – delivery and postpartum care are listed separately.

2. If an uncomplicated obstetrical patient is transferred from one physician to another physician for obstetrical care, the appropriate assessment benefit may be charged by the second physician, followed by prenatal visits. This statement does not apply to physicians substituting for each other or when the second physician sees the patient for the first time in labour. If the obstetrical patient is referred to a consultant for obstetrical care because of the complexity, obscurity or seriousness of the case, the consultant may claim a consultation in addition to the prenatal visits.

3. Illnesses resulting from or associated with pregnancy or false labour requiring added home or hospital visits, shall be claimed on a per visit basis.

4. When a pregnant patient visits her physician for a condition unrelated to her pregnancy and apart from her routine scheduled prenatal visits, the physician may charge the appropriate visit benefit.

5. The listings under the heading Referred Services may be claimed by the consultant physician in addition to the appropriate consultation or visit benefit. They may not be claimed by physicians providing obstetrical care to their own patients.

6. If a consultant is requested by another physician to perform a surgical induction of labour, or emergency removal of a Shirodkar suture (except at delivery) assuming someone else has inserted the suture, the consultant should claim consultation benefit for this (these) service(s).

7. Medical induction or stimulation of labour may be claimed once per pregnancy by any one physician and only when carried out for a recognized obstetrical complication(s) and does not qualify for detention benefits.

8. The listings for "Attendance at labour and attendance at delivery" and for "Attendance at delivery" may not be claimed by any physician when a patient is transferred to a second physician for normal obstetrical care.

9. Ordinary immediate care of the newborn is included in the labour-delivery fee and when the service is rendered by the anæsthetist, it is included in the anæsthetic benefit. Active resuscitation of the newborn provided by any physician may be claimed under codes G521, G522 (Life Threatening Emergency Situation).

10. When a physician provides newborn care and also performs a circumcision on the same newborn or infant, both services may be claimed.

11. When an obstetrician routinely transfers all newborns to another physician, the latter should not claim consultation benefit for these "transferrals". If the baby is well, the physician should charge the newborn care in hospital benefit plus for attendance at maternal delivery if this service is given. If the baby is sick, the physician may claim a general assessment and for attendance at maternal delivery (if this service is given) plus daily visits for as long as his services are required. If an obstetrician normally cares for newborns himself or transfers the care of newborns to a family physician but refers a newborn to a pædiatrician because of the complexity, obscurity or seriousness of the case, the latter may claim for this service according to the following guidelines:

a) If attendance at maternal delivery is provided, code H267 may be claimed and if a general assessment of the baby is carried out, code C263 may be claimed as well. However, a postnatal consultation of the baby, code C265 may not be claimed in addition to code H267.

b) If a pædiatrican has not attended delivery, a postnatal consultation may be claimed (if this service is rendered) even though a prenatal consultation may already have been claimed.

12. When a physician provides prenatal visits, attends labour, assists or administers the anæsthetic at Cæsarean section and visits the patient post-operatively, he is entitled to claim for prenatal visits, attendance at labour, assistant's or anæsthetist's benefits for Cæsarean section, and postoperative supportive care while the patient is in hospital.

13. Physicians may claim for assisted breech delivery (P020) when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and aftercoming head.

14. The Preamble applicable to Surgical Procedures (pages 55-57) also applies to obstetrics where appropriate.

15. The premiums applicable to Obstetrics are as follows: When deliveries and other obstetrical procedures done in continuity with the delivery **occur** after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the procedural fee(s) by 20% (E409). When time of delivery occurs after midnight and before 7:00 a.m. any night during the week, increase the procedural fee(s) by 50% (E410). These premiums are not chargeable in addition to the obstetrical procedural fee(s) if labour is induced by medical and/or surgical means by the same physician **unless the reason for the induction is fetal distress, diabetes, severe pre-eclampsia-hypertension or abruption.** However a forewater A.R.M. or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

OBSTETRICS

Code	OBSTETRICAL CARE	Assistant	Obstetrician	Relative Value Units	Anæsthetist
	Prenatal Care:				
P003	–General assessment (major prenatal visit)		$ 37.10		
P004	–Minor **prenatal** assessment (all other prenatal visits)		13.10		
	Labour–Delivery:				
P006	–Vaginal		176.25	23.5	
P020	–Operative delivery i.e. mid-cavity rotation or assisted breech delivery		195.00	26.0	5
P018	– Cæsarean section	6	198.75	26.5	6
P041	–Cæsarean section including tubal interruption	6	217.50	29.0	6
P042	–Cæsarean section including hysterectomy	8	487.50	65.0	8
E500	Multiple births, any method of delivery–each child, extra		63.75	8.5	
	(If one child is born vaginally and the other(s) by Caesarean section, claim P018, P041 or P042 plus **one at 85% of P006 or P020, then E500 for third and subsequent births.**)				
P038	Attendance at labour only (when patient is transferred to another centre for delivery)		82.50	11.0	
P009	Attendance at labour with physician in attendance at delivery		176.25	23.5	
P011	Attendance at labour (when same physician assists or gives anæsthetic at Cæsarean section or gives anæsthetic at operative delivery and claim separately for these services as assistant or anæsthetist)		120.00	16.0	
P010	Attendance at delivery (attending physician or consultant(s)		82.50	11.0	
P028	Repair of third decree laceration i.e. repair of anal sphincter and rectal mucosa		67.50	8.5	4
Z774	Postpartum hæmorrhage–exploration of vagina and cervix, uterine curettage		67.50	9.0	5
P007	Post natal care in hospital and/or home		41.25	5.5	
P008	Post natal care in office		17.40	–	
	Referred Services (I.O.P.)–when only service(s) rendered				
P036	Repair of vaginal laceration		45.00	5.0	4
P039	Repair of cervical laceration		45.00	5.0	4
P029	Manual removal of retained placenta		45.00	5.0	4
P013	Obstetrical anæsthesia				5
	Continuous conduction anæsthesia				
P014	(a) introduction of catheter for analgesia including first dose				6
P015	(b) maintenance and/or supervision **(one unit for each ½ hour to a maximum of 5 units – not to be claimed for first hour following introduction of catheter and first dose)**				
E100C	(c) attendance at delivery–per ¼ hour–time units				
G224	Pudendal block (bilateral)–see para. 37 (*r*) on page xi		11.25	–	
	High Risk Pregnancies				
Z776	Fetal blood sampling (I.O.P.)		26.25	3.5	
Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis) (I.O.P.)		127.50	17.0	
Z739	Oxytocin challenge test (I.O.P.)		37.50	5.0	
Z734	**Double set up examination to rule out placenta praevia, or trial of forceps–failed leading to Caesarian section (same physician)**		**45.00**	**6.0**	
P022	Oxytocin infusion for induction of labour–see paragraph 7		52.50	7.0	
P023	Oxytocin infusion for stimulation of desultory labour		52.50	7.0	
Z721	Pharmacological suppression of premature labour by I.V. therapy–to be claimed once per pregnancy by most responsible physician after 3 hours of supervision in same institution (I.O.P.)		52.50	7.0	
Z778	Amniocentesis–diagnostic or genetic (I.O.P.)		37.50	5.0	
P031	Suture of incompetent cervix during pregnancy (I.O.P.) (Shirodkar procedure)	3	112.50	13.0	4
	Elective removal of Shirodkar suture		visit fee		
P034	Uterine inversion, manual replacements		97.50	13.0	4

(Listings for ectopic pregnancy, hysterotomy, abortion and postpartum tubal interruption are on pages 120-121)

SURGICAL PROCEDURES

Preamble–FOR DEFINITION OF THE ROLE OF THE REFERRING PHYSICIAN, SEE REFERRING PHYSICIAN SERVICES ON PAGE ix.
FOR DEFINITION OF THE ROLES OF THE ANAESTHETIST, SEE ANAESTHETIST SERVICES ON PAGES x and xi.

(1) The surgical benefit (except for those procedures marked I.O.P., Complete Care and Fractures and Dislocations requiring no reduction) includes hospital visits rendered by the surgeon two days prior to surgery, the operative procedure, the post-operative care usually associated with the procedure(s) rendered by the surgeon while the patient is in hospital, and one office visit for follow-up examination, if necessary. If the surgeon is required to perform a procedure(s) not usually associated with the original surgical procedure, he may claim for these on a fee for service basis. If special visits to hospital are required at any time post-operatively, the surgeon may claim the special visit premiums even if the basic hospital visit fees are not chargeable. The surgical benefit as noted above does not include the major pre-operative visit i.e. the consultation or assessment fee chargeable when the decision to operate is made and the operation is scheduled, regardless of the time interval between the major pre-operative visit and surgery. The hospital or day-care admission assessment (consultation, repeat consultation, general or specific assessment or re-assessment) is not a benefit to the surgeon unless it happens to be the major pre-operative visit as defined above. Hospital visits (minor assessments) may be claimed for visits rendered more than two days prior to surgery. Other visits (excluding admission assessments) prior to admission may be claimed for in addition to the surgical fee. For patients remaining in hospital because of complications or hospital visit fees may be claimed in addition to the surgical or procedural fee after eight weeks of hospitalization in the case of fractures and dislocations and after two weeks for other procedures. Because the number of hospital visits is limited to three per week after the fifth week of hospitalization and six per month after the thirteenth week of hospitalization, the starting point for calculating the number of hospital visits is based on the date of admission if the operating surgeon has admitted the patient or the date of referral if the patient has been referred to the operating surgeon while in hospital. The surgical benefit includes the generally accepted surgical components of the procedure. The listed benefit of a procedure normally also includes any necessary repair of iatrogenic damage occurring during the course of the surgery.

(2) When a physician makes a special trip to perform a non-elective surgical procedure during the daytime (Monday to Friday), he should claim the appropriate special visit, a consultation if the case is referred (except for fractures or dislocations requiring no reduction) or the appropriate assessment if the case is not referred plus the procedural benefit(s). When the special visit is to deal with fractures or dislocations requiring no reduction, the minor or partial assessment fee is the appropriate benefit to be added to the special visit and fracture or dislocation fees. If the non-elective procedure is carried out at night (after 5:00 p.m. and before 7:00 a.m.), or Saturdays, Sundays and Holidays, the physician may claim the special visit applicable to the consultation or assessment, and the surgical premium (E409 or E410 – see paragraph 46 of the Preamble).

(3) When more than one procedure is carried out by a surgeon under the same anæsthesia or within 14 days during the same hospitalization for the same condition, the full benefit applies to the major procedure and 85% of the listed benefit(s) applies to the other procedure(s) performed unless otherwise stated in the Preamble(s) or Schedule. The above statement applies to staged or bilateral procedures but does not apply when a normal appendix or simple ovarian or para-ovarian cyst is removed incidentally during an operation, for which no claim should be made.

(4) When a subsequent operation becomes necessary for the same condition because of a complication or for a new condition, the full benefit should apply for each procedure.

(5) When a subsequent non-elective procedure is done for a new condition by the same surgeon, the full benefit will apply to each procedure. When a subsequent elective procedure is done for a different condition within 14 days during the same hospitalization by the same surgeon, the benefit for the lesser procedure shall be reduced by 15%.

(6) When different operative procedures are done by two different surgeons under the same anæsthesia for different conditions, the benefit will be 100% of the listed benefit for each condition. Under these circumstances, the basic assistants' benefit should not be charged by either operating surgeon; however time units may be claimed.

(7) As a general rule, when elective bilateral procedures are performed by two surgeons at the same time, one surgeon should charge for the surgical procedures and the other surgeon should claim the assistant's benefit.

(8) Where two surgeons are working together in surgery in which neither a team fee or other method of billing is set out in the benefit schedule, the surgeon should identify himself as the operating surgeon and claim accordingly; the surgeon who is assisting him should identify himself as such and claim the assistant's benefit. Where the second or assistant surgeon is brought into the case on a consultation basis, he may, when indicated, claim a consultation as well but should be prepared to justify it on an I.C. basis. If the nature or complexity of a procedure requires more than one operating surgeon each

providing a separate service in his own specialized field e.g. one surgeon carries out the ablative part and another surgeon the reconstructive part of the procedure, then each surgeon should claim the listed benefit for his services. This statement applies when the additional procedure(s) are not the usual components of the main procedure. If one surgeon in addition to performing a specialized portion of a procedure, acts as an assistant during the remainder of the procedure, he may also claim time units for assisting.

(9) Unless otherwise stated, the listed benefits are for unilateral procedures only.

(10) When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 11), is not in keeping with the intent of the benefit schedule.

(11) When a surgical benefit (non I.O.P., Complete Care, Fracture or Dislocation) is less than the consultation benefit and the case is referred, the physician may claim the consultation benefit instead of the surgical benefit. However, to avoid the consultation being counted as such under the OHIP limitation rules on the number of consultations allowed per year, the physician should claim the consultation fee under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.

(12) If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician should claim for the procedure as well as the appropriate assessment.

(13) Where a procedure is specified as "Independent Operative Procedure (I.O.P.)", the procedural benefit should be claimed in full along with the appropriate consultation or visit when both services are actually rendered. However, when an I.O.P. procedure is done in conjunction with a non-I.O.P. procedure, there should be no claim for the consultation, pre- and post-operative care related to the I.O.P. procedure. The listed I.O.P. benefit should be claimed in these circumstances along with the non-I.O.P benefits plus the related major pre-operative visit (see paragraph (1) of Surgical Preamble). When multiple or bilateral I.O.P. procedures are performed at the same time by the same physician, the listed procedural benefits should be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed. When a patient is examined in a physician's office and this leads to an elective Independent Operative Procedure (I.O.P.) being performed for the same problem or diagnosis by the same physician in the Emergency or Outpatient Department on a non-admission basis, the physician should claim a consultation or visit for the examination in the office and the benefit for the I.O.P. carried out in the Emergency or Outpatient Department. An additional assessment benefit at the time of the elective I.O.P. should only be claimed when an additional assessment is performed.

(14) When procedures are specifically listed under Surgical Procedures, surgeons should use these listings rather than applying one of the plastic surgery fees listed under Operations on Skin and Subcutaneous Tissue.

(15) For excision of tumours not specifically listed in this Schedule, physicians should claim on an Independent Consideration (I.C.) basis (R993). For other unusual but generally accepted surgical procedures (excluding non-major variations of listed procedures) which are not specifically listed in the Schedule, physicians should also charge on an I.C. basis (R990).

(16) Cosmetic or Aesthetic Surgery: means a service to enhance appearance without being medically necessary such as (a) surgery for correction of facial wrinkles; (b) surgery for eyelid wrinkles (symmetrical and without a functional problem); (c) rhinoplasty for appearances only; and (d) augmentation mammoplasty for symmetrical deficiency without physiological abnormality.
These services are not benefits of OHIP. (See Preamble, Appendix A).

(17) Reconstructive Surgery: is surgery to improve appearance and/or function to any area altered by disease, trauma or congenital deformity. Although surgery solely to restore appearance may be included in this definition under certain limited conditions, emotional, psychological or psychiatric grounds normally are not considered sufficient additional reason for OHIP coverage of such surgery

Appendix D of the Preamble to this Schedule describes the conditions under which surgery for alteration of appearance, only, may be a benefit of the Plan.

Physicians should submit requests to their District OHIP office for authorization of any proposed surgery which may fall outside of OHIP coverage. (see appendix D).

(18) Procedural benefits (non I.O.P.) include the removal of sutures when both services are rendered by the same physician unless the removal of sutures is done on the second or subsequent office visit for follow up examination. When a physician is entitled to claim for removal of sutures i.e. as outlined in the previous sentence or is a physician other than the operating surgeon or following an I.O.P. procedure, an office visit may be claimed.

(19) Additional claims for biopsies performed when a surgeon is operating in the abdominal or thoracic cavity should be given independent consideration.

SURGICAL PROCEDURES

(20) When a listed procedure is performed and no anaesthetic is required, the procedure should be claimed under the "local anaesthetic" listing.

(21) When a physician administers an anaesthetic and/or other medication prior to or during a procedure(s) and also performs a procedure(s) on the same patient, he should claim for the procedure(s) only. However, when a physician administers a pudendal, femoral, intercostal, sciatic, ilioinguinal, iliohypogastric, ulnar, median or radial block in addition to performing a procedure, he may claim $11.25 (G224) in addition to the procedure.

(22) If claims are being submitted in coded form, the surgeon should add the suffix A to the listed procedural code, the surgical assistant should add the suffix B to the listed procedural code and the anæsthetist should add the suffix C to the listed procedural code.

OPERATIONS ON THE INTEGUMENTARY SYSTEM

SKIN AND SUBCUTANEOUS TISSUE

Code		Assistant	Surgeon	Anæsthetist
	Incision (I.O.P.)			
	Abscess or Hæmatoma			
Z101	local anæsthetic–subcutaneous–one		$ 14.70	
Z173	–two		22.20	
Z174	–three or more		29.70	
Z104	–perianal		14.70	
Z106	–ischiorectal or pilonidal		32.40	
Z103	–palmar or plantar spaces.		32.40	
Z102	general anæsthetic–subcutaneous–one		32.40	4
Z172	–two or more		48.75	4
Z105	–perianal		32.40	4
Z107	–ischiorectal or pilonidal		52.70	4
Z108	–palmar or plantar spaces		52.70	4
Z119	Comedones, acne pustules, milia–ten or less		2.80	
Z120	–eleven or more		9.90	
Z114	Foreign body removal–local anæsthetic		13.80	
Z115	–general anæsthetic	3	64.90	4
Z100	–complicated	4	I.C.	4
Z227	Intramuscular abscess or haematoma		74.25	4
Z116	Biopsy(s)–any method–when sole procedure		10.70	
Z155	–extensive, complicated or requiring general anæsthetic when sole procedure		I.C.	I.C.
Z245	Biopsy for malignant hyperthermia, three or more		111.40	10
	Excision (with or without biopsy)			
	Lesions–single or multiple sites (I.O.P.)			
	Group 1–verruca, papilloma, keratosis, pyogenic granuloma, spider nævus			
Z156	Removal by excision and suture–single lesion		10.80	4
Z157	–two lesions		16.20	4
Z158	–three or more lesions		27.00	4
	Removal by electrocoagulation and/or curetting			
Z159	–single lesion		7.70	4
Z160	–two lesions		11.60	4
Z161	–three or more lesions		19.10	4
	Group 2–nævus			
Z162	Removal by excision and suture–single lesion		10.80	4
Z163	–two lesions		16.20	4
Z164	–three or more lesions		27.00	4
Z165	Congenital (extensive)		I.C.	I.C.
	Note: Nævi removed for cosmetic purposes and not for any clinical suspicion of disease or malignancy may be billed to the patient.			
	Group 3–plantar verruca			
Z166	Removal by excision and suture–single lesion		21.20	4
Z167	–two lesions		31.70	4
Z168	–three or more lesions		52.70	4
	Removal by electrocoagulation and/or curetting			
Z169	–single lesion		14.70	4
Z170	–two lesions		22.20	4
Z171	–three or more lesions		43.80	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	SKIN AND SUBCUTANEOUS TISSUE–Cont'd.	Assistant	Surgeon	Anæsthetist
	Group 4–cyst, hæmangioma, lipoma			
	Face or neck			
Z122	local anæsthetic –single lesion		$ 23.55	
Z123	–two lesions		34.80	
Z124	–three or more lesions		47.90	
Z145	general anæsthetic–single lesion	3	48.00	4
Z146	–two lesions	3	72.00	4
Z147	–three or more lesions	3	96.00	4
Z148	–extensive or massive	3	I.C.	5
	Other areas			
Z125	local anæsthetic –single lesion		18.15	
Z126	–two lesions		28.00	
Z127	–three or more lesions		36.50	
Z149	general anæsthetic–single lesion	3	36.50	4
Z150	–two lesions	3	48.00	4
Z151	–three or more lesions	3	72.00	4
Z152	–extensive or massive	3	I.C.	5
R034	**Congenital dermoid cyst**	3	90.00	4
R037	**Giant cell tumour**	3	90.00	4
R035	**Pilonidal cyst**–simple excision or marsupialization	3	135.00	4
R036	–excision and skin shift	3	180.00	4
	Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hidradenitis			
R059	–unilateral	3	191.25	5
R060	–with skin graft(s) or rotation flap(s)	3	283.75	6
	Malignant Lesions including biopsy of each lesion			
	–single or multiple sites			
	Simple excision–face or neck			
R048	–single lesion	3	53.10	4
R049	–two lesions	3	86.90	4
R050	–three or more lesions	3	173.90	4
	Simple excision–other areas			
R094	–single lesion	3	42.50	4
R040	–two lesions	3	69.50	4
R041	–three or more lesions	3	139.10	4
E540	**–if excision is performed in hospital for tumour free margin with frozen section, add 25%**			
	Curettage, electrodesiccation or cryosurgery–face or neck			
R018	–single lesion	3	50.20	4
R019	–two lesions	3	82.70	4
R020	–three or more lesions	3	165.45	4
	Curettage, electrodesiccation or cryosurgery–other areas			
R031	–single lesion	3	40.20	4
R032	–two lesions	3	66.20	4
R033	–three or more lesions	3	132.40	4
R081	Chemosurgery (Mohs technique)		I.C.	I.C.

Note: When excision of benign or malignant lesions are corrected by advancement, rotation, transposition, "Z" plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of foregoing excision benefits.

Code		Assistant	Surgeon	Anæsthetist
	Repair			
	Debridement and Dressing (I.O.P.)–not chargeable in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care			
U.V.C.	–minor		visit fee	
Z153	–major (not chargeable in addition to Z176)		10.10	
Z144	–requiring general anæsthetic	4	41.25	4
R082	–extensive	4	I.C.	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	SKIN AND SUBCUTANEOUS TISSUE–Cont'd.	Assistant	Surgeon	Anaesthetist
	Burns (I.O.P.)			
Z180	Resucitation–major burn, initial care, 1st 24 hours		$ 78.75	
Z181	–continuing care (up to 3 days), per day		39.40	
R637	Debridement and excision, per % of burned area of total body treated other than hand, head or neck		11.25	
	Debridement and excision			
R660	**–hand, each digit**		**11.25**	
R661	**–dorsum palm–each**		**18.75**	
R662	**–nose, cheek(s), lip(s), ear(s), forehead, scalp neck, eyelid–each**		**11.25**	
R638	Excision and graft of burn, per % of burned area of total body treated other than hand, head or neck		22.50	
	Excision and graft of burn			
R663	**–hand, each digit**		**22.50**	
R664	**–palm, dorsum–each**		**45.00**	
R665	**–nose, lip(s)–each**		**75.00**	
R666	**–cheek(s), forehead–each**		**90.00**	
R667	**–ear**		**112.50**	
R668	**–eyelid**		**131.25**	
R669	**–scalp, less than 10%**		**37.50**	
R670	**up to 50%**		**112.50**	
R671	**over 50%**		**I.C.**	
R672	**–neck, less than 10%**		**45.00**	
R673	**up to 50%**		**135.00**	
R674	**over 50%**		**I.C.**	
	Suture of Lacerations (I.O.P.)			
Z176	**–up to 5 cm.**		**10.90**	
Z154	**–up to 5 cm. if on face and/or requires tying of bleeders and/or closure in layers**		**26.60**	
Z175	**–5.1 to 10 cm.**		**26.60**	
Z177	**–5.1 to 10 cm. if on face and/or requires tying of bleeders and/or closure in layers**		**53.25**	
Z179	**–10.1 to 15 cm.**		**37.50**	
Z190	**–10.1 to 15 cm. if on face and/or requires tying of bleeders and/or closure in layers**		**75.00**	
Z191	**–more than 15.1 cm.**		**I.C.**	
E530	**–if inhalation general anaesthesia (other than 50% NO_2/O_2 mixture) is used, add**		**37.50**	**4**
E531	**–if extensive debridement is required, add**		**I.C.**	
E542	–when sutures are inserted in private office, add		4.10	
	–removal of sutures only		visit fee	

Note: The above benefits include the use of sutures, local anaesthetic, tetanus toxoid and routine observation until the sutures have been removed.

Code	**Muscle Repair**	Assistant	Surgeon	Anaesthetist
R525	Simple muscle repair(s) to include repair of involved skin	3	$ 66.00	4
R528	Complex	4	I.C.	6

Skin Flaps and Grafts–The benefit will depend on the size and location of the area grafted and the type of graft. Additional procedures other than the skin grafting are extra, e.g. tendon grafts, inlay grafts, etc. Skin flaps or grafts done during a procedure should be claimed on their own merit (unless specifically listed as being inclusive for that procedure).

Skin Flaps

A. Advancement Flaps (to include undermiaing of more than 2.5 cm per side)–is intended to include excision of a lesion or scar if this is technique of closure

Code		Assistant	Surgeon	Anaesthetist
R011	**If defect is 2.1 to 5 cm–face or neck**	**3**	**65.50**	**4**
R002	–other areas	3	43.70	4
R012	**If defect is 5.1 to 10 cm–face or neck**	**3**	**99.00**	**5**
R003	–other areas	3	66.00	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	SKIN AND SUBCUTANEOUS TISSUE–Cont'd.	Assistant	Surgeon	Anæsthetist
R004	If beyond 10 cm such as thoracic abdominal flap	4	I.C.	6
	B. Rotations, Transpositions, "Z" plasty (includes undermining) but will depend on the site and size.			
R045	**Defect less than 2 cm average diameter–face or neck**	3	**$ 153.00**	4
R072	**–other areas**	3	**102.00**	4
R046	**Defect 2.1 to 5 cm average diameter–face or neck**	3	**256.50**	4
R075	**–other areas**	3	**171.00**	4
R047	**Defect 5.1 to 10 cm average diameter–face or neck**	4	**365.60**	4
R073	**–other areas**	4	**243.75**	4
R074	Defect more than 10 cm average diameter	4	I.C.	5
	C. Pedicle Flaps			
R079	Small e.g. cross finger	4	102.00	4
R077	–each subsequent stage	4	76.50	4
R070	Intermediate e.g. cervical finger	4	225.00	5
R071	–each subsequent stage	4	171.00	5
R080	Large e.g. cross leg, **deltopectoral, forehead**	4	318.75	6
R078	–each subsequent stage	4	238.50	6
R103	Delay of tube or pedicle		48.40	4
R101	**Delay, intermediate flap**	3	101.25	4
R100	**Delay, major flap**	4	223.50	5
	D. Myo-Cutaneous Flaps (to include closure by any means)			
R005	**Sterno-mastoid, tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), trapezius**	3	**361.10**	5
R006	**Pectoralis major, latissimus dorsi, unilateral rectus abdominus**	4	**562.50**	6
R008	**Lower transverse rectus abdominus flap**	6	**487.50**	8
Z195	**–repair of abdominal defect–same surgeon**		**150.00**	
Z196	**–different surgeon**		**288.75**	
R009	Myocutaneous–osseous flaps e.g. pectoralis major myocutaneous flap with rib graft, trapezius flap with scapular spine	6	600.00	8
R007	Other	I.C.	I.C.	I.C.
	Skin Grafts			
	A. Split Thickness Grafts			
R084	Very minor, very small areas, e.g., trauma		70.50	4
R085	Minor, medium sized areas, e.g. small or skin ulcer, breast, etc.	3	107.25	4
R086	Intermediate, large areas, e.g. trunk, arms, legs	4	198.75	4
R087	Major, complex areas, e.g., face, neck, hands	4	297.40	5
R088	Extensive major, very large area(s)	4	435.00	6
	B. Full Thickness Grafts			
R092	Minor–less than 1 cm. average diameter		71.60	4
R093	Intermediate–1 cm. to 5 cm. average diameter	3	109.50	4
R083	Major–over 5 cm	5	I.C.	5
R091	Complex–eyelid, nose, lip, face	4	161.25	5
R057	**Appendage or tissue re-vascularization** involving microanastomosis with or without micro neuroanastomosis	I.C.	I.C.	I.C.
R058	Revision of above	I.C.	I.C.	I.C.
	Stasis Ulcer			
R847	**–with skin graft–per leg**	3	**150.00**	5
R845	**–multiple ligation and skin graft–per leg**	5	**255.00**	5
	Neurovascular Island Transfer			
R061	Minor e.g. finger tip	3	107.25	4
R062	Intermediate e.g. finger to thumb transfer	4	198.75	5
R063	Major e.g. foot to heel	4	330.00	6
	Free Island Flaps			
R064	Elevation of free island skin and subcutaneous flap and closure of defect	10	637.50	10

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	SKIN AND SUBCUTANEOUS TISSUE–Cont'd.	Assistant	Surgeon	Anaesthetist
R065	Preparation of microvascular recipient site for free island skin subcutaneous flap		$675.00	
R066	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis		675.00	
R067	Elevation of innervated free island skin and subcutaneous flap and closure of defect	10	750.00	10
R068	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap		750.00	
R069	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis and nerve repair		701.25	
R125	Elevation of free island skin and muscle flap and closure of defect	10	637.50	10
R126	Preparation of microvascular recipient site for free island skin and muscle flap		675.00	
R127	Transplantation of free island skin and muscle flap with microvascular anastomosis		637.50	
R128	Elevation of free island muscle flap with tendon and nerve, and closure of defect	10	862.50	10
R129	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis		862.50	
R130	Transplantation of free island muscle flap with tendon, nerve and microvascular anastomosis		862.50	
R131	Elevation of free island bone flap and closure of defect	10	637.50	10
R132	Preparation of microvascular recipient site for free island bone flap		675.00	
R133	Transplantation of free island bone flap with microvascular anastomosis and bone fixation		750.00	
R134	Elevation of free island skin and bone flap and closure of defect	10	765.00	10
R135	Preparation of microvascular recipient site for free island skin and bone flap		765.00	
R136	Transplantation of free island skin and bone flap with microvascular anastomosis and bone fixation		765.00	
R137	Elevation of free toe or finger and closure of defect	10	765.00	10
R138	Preparation of microvascular recipient site for free toe or finger transplant		765.00	
R139	Transplantation of free island toe or finger with microvascular anastomosis and tendon nerve and bone repair		900.00	
R025	Revision of free island flaps	10	I.C.	10
R106	**Skin Flaps and Grafts**–other than listed above	I.C.	I.C.	I.C.
	Destruction			
Z121	Epilation of facial hairs (I.O.P.)–per quarter hour		12.60	
	Finger or toe-nail (I.O.P.)			
Z128	Simple, partial or complete–one		17.60	4
Z129	–multiple		26.25	4
	Radical, including destruction of nail bed			
Z130	–one		44.25	4
Z131	–multiple		61.50	4
	Chemical and/or cyrotherapy treatment of minor skin lesions (I.O.P.)			
Z117	–one or more lesion, per treatment		8.00	
	Plastic Planing (Dermabrasion)–face for acne			
R096	–each area		75.00	4
R104	–both cheeks		157.50	4
R097	–whole face		240.00	4
R098	–single area, e.g., trauma scar		43.10	4
R099	**Rhinophyma**, removal by shaving		193.10	4
R089	**Webbed Fingers**–one web space	4	206.60	5
R090	**Webbed Toes**–one web space	4	95.10	4
	Scar Revision			
R021	**up to 2.5 cm–face or neck**	**3**	**67.50**	**4**
R026	**–other areas**	**3**	**45.00**	**4**

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	SKIN AND SUBCUTANEOUS TISSUE–Cont'd.	Assistant	Surgeon	Anæsthetist
R022	**2.6 to 5 cm–face or neck**	3	**$101.25**	4
R027	**–other areas**	3	**67.50**	4
R023	**5.1 cm to 10 cm–face or neck**	3	**202.50**	5
R028	**–other areas**	3	**135.00**	5

Plastic Surgery Procedures:

The setting of benefits covering the various procedures of plastic surgery is a very difficult problem. Since many procedures are divided into stages which have to be considered in assessing a fee, it is felt that all such plastic surgical procedures should be classed by the responsible specialist as very minor, minor, intermediate, major, or extensive major. Benefits should be claimed according to procedures set forth in the tariff, except in cases which are difficult to define, in which case "I.C." should be the basis of the claim. The minimum benefit for each would be as follows:

Code		Assistant	Surgeon	Anæsthetist
R150	Very Minor		70.50	4
R151	Minor	3	108.00	4
R152	Intermediate	4	198.75	4
R153	Major	4	296.25	5
R154	Extensive Major	4	435.00	6
R155	**Insertion of tissue expander**	3	**150.00**	5
R156	**Percutaneous inflation of tissue expander**		**17.25**	
R157	**Replacement of tissue expander by permanent prosthesis**		**75.00**	4

OPERATIONS ON THE BREAST

Incision

Code		Assistant	Surgeon	Anæsthetist
Z141	Needle biopsy–one or more (I.O.P.)		18.00	
Z139	Aspiration of cyst–one or more (I.O.P.)		18.00	
	Drainage of intramammary abscess or hematoma–single or multi loculated (I.O.P.)			
Z140	–local anæsthetic		18.00	
Z740	–general anæsthetic		45.00	4

Excision

Code		Assistant	Surgeon	Anæsthetist
R107	Tumour or tissue for diagnostic biopsy and/or treatment e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple–same breast)	3	97.50	4
R111	Partial mastectomy or wedge resection for treatment of breast disease e.g. carcinoma or extensive fibrocystic disease	3	146.25	4
E546	–with radical axillary node dissection, add		172.50	
	Mastectomy–male (benign)–unilateral			
R115	–simple	3	127.50	4
R116	–subcutaneous with nipple preservation	4	195.00	5
	Mastectomy–female (with or without biopsy)			
R108	–simple	4	195.00	5
R117	–subcutaneous with nipple preservation	4	195.00	5
R109	Mastectomy, radical or modified radical (with or without biopsy)	5	360.00	6

Repair

Code		Assistant	Surgeon	Anæsthetist
	Post-mastectomy breast reconstruction			
R119	–breast mound creation by prosthesis and/or soft tissue	4	225.00	5
R118	–breast skin reconstruction by local flaps or grafts	4	300.00	5
E529	**–with breast mound creation by prosthesis and/or soft tissue, add**		**75.00**	
	–by myocutaneous flaps–see codes R005-R009			
R114	**–revision of breast mound**	3	**172.50**	4
R113	**Nipple-areola preservation and tissue-banking**	3	**86.25**	4
R121	**Reimplantation of tissue-banked nipple-areola**	3	**103.10**	4
R120	**Nipple-areola reconstruction by grafts**	3	**172.50**	4
R110	Reduction mammoplasty (female, to include nipple transplantation or grafting)–unilateral	5	352.50	7

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	OPERATIONS ON THE BREAST–Cont'd.	Assistant	Surgeon	Anæsthetist
R112	Augmentation mammoplasty–unilateral	4	$150.00	4
Z142	Removal of breast prosthesis (I.O.P.)	3	57.40	4
Z133	Breast capsulotomy closed (I.O.P.)–no anæsthetic		9.20	
Z134	–general anæsthetic	3	57.40	4
Z135	Open capsulotomy with or without replacement of breast prosthesis (I.O.P.)	3	142.50	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Preamble:

(1) **Corrective splints must be "corrective" to qualify for a benefit as such. The corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or metal finger splint following soft tissue injury.**

(2) The removal of a wire or pin or other device when used for traction or external fixation **(except for rigid external fixators)** in the treatment of a fracture or other orthopædic procedure is to be included in the procedural fee. Removal of devices used for internal fixation **more than 30 days** may be charged for in addition to the procedural benefit.

(3) The benefit for total hip replacement also includes denervation of the hip joint and adductor tenotomy.

(4) The benefit for obtaining a bone graft is not to be claimed in cases of pseudarthrosis repair, fusions or for listings in which bone grafting is included.

(5) For the supervision of limb fitting and 6 months post-operative care following amputation, claim visit fees. Amputation with immediate fitting to include supervision of final limb fitting – add 40% (E586).

(6) **Arthroscopic surgery shall constitute an anthrotomy for the purposes of this schedule and procedures shall command the same benefits.**

Fractures and Dislocations:

(a) The fracture or dislocation benefits for services requiring no reduction include the major pre-operative visit. For fractures or dislocations requiring open or closed reduction, the major pre-operative visit i.e. consultation or appropriate assessment may be claimed in addition to the listed benefits for open or closed reductions.

(b) OPEN REDUCTION shall mean the treatment of a fracture or dislocation **by either closed intramedullary fixation or by an operative procedure to expose the fracture. The benefits include fixation by internal or external devices.**

(c) CLOSED REDUCTION shall mean the reduction of a fracture or dislocation by non-operative methods (including traction).

(d) NO REDUCTION shall mean the treatment of a fracture or dislocation by any other method and includes the use of the initial external support.

(e) The stated benefit covers full or after treatment up to 8 weeks except if additional reductions are necessary or if patient is transferred to another surgeon or if the patient is parapalegic.

(f) In multiple fractures or dislocations, the benefit for the major fracture or dislocation shall be 100% and the benefit for the other fractures or dislocations 85%. When no procedural benefit is applicable, but when that fracture or dislocation necessitates hospitalization or concurrent care over that demanded by the major injury, a visit benefit may be claimed in addition to other procedural benefits.

(g) For repeat reductions (closed or open) for the same fracture or dislocation, the full benefit should be claimed for the final reduction and after care–previous reductions by the same surgeon should be claimed at 85%.

(h) Emergency splinting of fractures in the emergency department should be on the basis of the appropriate visit benefit, plus application of cast if appropriate.

(i) Transferred cases –

  (1) When patients are transferred to a chronic or convalescent facility, additional visit benefits on a chronic care basis shall be allowed to other than the operating surgeon (and also to the surgeon after 8 weeks).

  (2) When patients are transferred to another physician for after care of fractures and dislocations treated by closed or no reduction, the physician rendering the initial care should claim 75% of the listed fee and the surgeon rendering subsequent care visit fees except where otherwise specified. In cases involving open reduction, the percentage should be 80% for the surgeon providing the initial care.

  (3) **In cases where the original physician attempts to reduce a fracture or disclocation, is unsuccessful and refers the patient to another physician for definitive care, the original physician should claim 50% of the listed fee when a general anæsthetic is not used and 85% when it is.**

(j) Paraplegia associated with fractures and dislocations may be claimed by charging visit fees after the first 2 weeks of post-operative care in addition to the appropriate procedural fees.

(k) Pseudarthrosis may be allowed as the appropriate benefit after the fracture is 4 months old.

(l) For fractures and dislocations not requiring reduction, visit fees apply unless a specific fee is listed. If the listed fee is less than the consultation, the consultation should be claimed under the fracture/dislocation code number.

Code	GENERAL FEES	Assistant	Surgeon	Relative Value Units	Anaesthetist
	Bone/Fascial/Dermis Grafts				
E551	Autogenous–separate incision		$ 54.90	7.3	
E552	–same incision		43.90	5.8	
Z242	–different surgeon (I.O.P.)		146.25	19.5	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	GENERAL FEES–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
E553	Homogenous–bank		21.90	2.9	
	Allograft–donor–85% of excision fee				
R200	– cadaver–**per long bone, each**		109.70	14.6	
	Fixation				
E547	Methyl methacrylate (not arthroplasty)		51.20	6.8	
E555	Rigid external fixation **(excluding casts), add 40% for closed reduction,** to closed reduction				
E569	Percutaneous pinning, add 30% to closed reduction				
E590	Rigid external fixation–pseudarthosis		58.50	7.8	
R267	Removal fixation device–general anæsthetic	3	109.70	14.6	4
R268	–local anæsthetic	3	36.60	4.9	4
R598	Removal of extensive external fixation device		36.60	4.9	4
Z210	Insertion traction pin–excludes fractures and dislocations (I.O.P.)		25.60	3.4	
	Wound Care				
Z783	Secondary closure		73.10	9.8	
E550	Closed irrigation during a surgical procedure		54.90	7.3	
E556	Extensive debridement of compound fractures or dislocations–add 40% to reduction fee				2
R517	Excision of foreign body		29.25	3.9	4
	Electrical Stimulation				
Z250	External or internal (I.O.P.)		146.25	19.5	4
	Casts (I.O.P.)				
	Application of plaster casts or corrective splints are not chargeable if applied at the time of surgery (except for the application of a cast brace) or applied during the first 8 weeks for a fracture or dislocation when a procedural fee is applicable. The subsequent application of plaster casts is chargeable according to the following schedule. Cost of material is extra.				
Z201	Finger		7.30	1.0	
Z202	Hand		11.00	1.5	4
Z203	Arm, forearm or wrist		18.30	2.4	4
Z199	Foot		11.00	1.5	4
Z213	Below knee, knee splints (Stove pipe, etc.)		18.30	2.4	4
Z211	Whole leg (mid thigh to toes)		21.90	2.9	4
Z198	Toes		7.30	1.0	4
Z205	Head and torso	3	73.10	9.8	4
Z208	Shoulder spica	3	73.10	9.8	4
Z206	Body cast	3	43.90	5.8	4
Z207	Hip spica–unilateral	3	73.10	9.8	4
Z209	–bilateral	3	91.40	12.2	4
Z216	Wedging of casts in other than fracture treatment		7.30	1.0	
Z200	Application of Unna's paste		11.00	1.5	
Z873	Application of cast brace (must include hinge)		51.20	6.8	
Z204	Removal of plaster (not associated with fractures or dislocation within 8 weeks of initial treatment)		7.30	1.0	

HAND and WRIST

Code	**Amputation**	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
R606	Phalanx		109.70	14.6	4
E582	–each additional		36.60	4.9	
R608	Metacarpal or metaphalangeal joint		146.25	19.5	4
E583	–each additional		36.60	4.9	
R610	Trans. metacarpal 2nd or 5th ray		219.40	29.2	4
R611	Hand–all metacarpals	3	219.40	29.2	4
R612	Wrist	4	219.40	29.2	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM—Cont'd.

Code	HAND and WRIST—Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
	Arthrodesis				
R465	Finger—thumb	3	$182.80	24.4	4
R466	Wrist	3	292.50	39.0	4
	Arthroplasty				
R437	Wrist—interposition	3	292.50	39.0	5
R485	—total	6	329.10	43.9	6
R479	Removal only	3	146.25	19.5	6
R435	Hand—interposition—single	3	182.80	24.4	5
R436	—multiple	3	329.10	43.9	6
R489	Single joint—total	3	219.40	29.2	5
R449	Multiple joints—total—max.	3	585.00	78.0	6
R500	Removal only	3	109.70	14.6	4
R236	Carpal replacement	3	146.25	34.1	5
E564	Revision of arthroplasty—add 35%				
	Arthroscopy (I.O.P.)				
Z219	Small joints		47.55	6.3	4
E595	Preceding surgery		47.55	6.3	
	Arthrotomy				
R409	Finger		109.70	14.6	4
R410	Wrist	3	146.25	19.5	4
	Aspiration/Injection—see page 47				
	Biopsy				
Z230	Bones—punch, x-ray control (I.O.P.)		54.90	7.3	4
Z214	—open biopsy or taking of bone graft by other than operating surgeon (I.O.P.)	4	109.70	14.6	4
E563	Joint—via arthroscope		7.30	1.0	
Z221	—needle (I.O.P.)		36.60	4.9	
R409	—open finger		109.70	14.6	4
R410	—open wrist	3	146.25	19.5	4
Z228	Muscle (I.O.P.)		73.10	9.8	4
	Decompression—Denervation				
N290	Decompression median nerve at wrist (carpal tunnel syndrome)	3	116.25	15.5	4
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding carpal tunnel nerve)	4	157.50	21.0	4
	Drainage				
R219	Incision and drainage—phalanx/metacarpal/carpus	3	98.70	13.2	4
R218	Sequestrectomy—phalanx/metacarpal/carpus	3	109.70	14.6	4
R217	Saucerization and bone graft phalanx/metacarpal/carpus	4	182.80	24.4	4
R409	Incision and drainage—joint (finger)		109.70	14.6	4
R410	—joint (wrist)	3	146.25	19.5	4
R534	Tendon sheath	3	87.75	11.7	4
	Examination/Manipulation				
	Manipulation—hand/wrist				
Z222	—under general anæsthetic		18.30	2.4	4
	—without general anæsthetic, see page 52				
	Excision—Bone				
R316	Proximal row carpectemy	3	255.90	34.1	5
R285	Carpal—bone (one)	3	146.25	19.5	4
R317	Dorsal exostosis (triquetrum)	3	146.25	19.5	4
R286	Radial styloid	3	146.25	19.5	4
R283	Phalanx/metacarpal	3	146.25	19.5	4
R272	Bone tumour	I.C.	I.C.	–	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM—Cont'd.

Code	HAND and WRIST—Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
	Excision—Joint				
R425	Synovectomy/**capsulectomy**/debridement—finger joint	3	$182.80	24.4	4
R414	—two or more joints	3	292.50	39.0	4
R407	**Synovectomy of extensor tendons**		**168.20**	**22.4**	4
R418	Synovectomy/debridement—wrist	3	292.50	39.0	4
R492	Radio-ulnar meniscectomy	3	164.55	21.9	4
	Excision—Muscle and Tendon				
R522	Muscle—simple		I.C.	–	I.C.
R523	—complex		I.C.	–	I.C.
R550	Tendon sheath—single	3	204.75	27.3	4
E572	—each additional, add		65.80	8.8	1 (max.)
R551	Fascia for Dupuytrens—simple	3	146.25	19.5	4
R552	—complex (with or without flaps or grafts)	3	292.50	39.0	5
	Excision—Ganglion				
R549	Simple	3	73.10	10.7	4
R553	Complex	3	I.C.	–	4
	Reconstruction—Bone				
R257	Osteotomy—phalanx—terminal		109.70	14.6	4
R258	—phalanx—middle proximal or metacarpal	3	146.25	19.5	4
E591	—each additional		29.25	3.9	
R321	Pseudoarthrosis—phalanx, metacarpal	3	182.80	24.4	4
R322	—scaphoid	3	219.40	29.2	4
	Reconstruction—Ligaments				
R597	Simple/single repair—wrist	3	146.25	19.5	4
R548	Extensive/multiple repair—wrist	3	329.10	43.9	4
R601	Metacarpal phalangeal repair	3	182.80	24.4	4
	Reconstruction—Nerve—see page 126				
	Reconstruction—Tendon				
R557	Tenoplasty—one	3	146.25	19.5	4
E050	—each additional, add		65.80	8.8	
R559	Tendon graft—one	3	219.40	29.2	4
E052	—each additional, add		95.10	12.7	1 (max.)
R586	Reconstruction of flexor tendon pulley, per finger		73.10	9.8	4
R554	Silicone rod insertion—one	3	219.40	29.2	4
E051	—each additional, add		95.10	12.7	
R563	Transplant/transfer—single	3	219.40	29.2	4
E054	—each additional, add		65.80	8.8	1 (max.)
R578	Tendon repair—extensor—single	3	95.10	12.7	4
E580	—each additional, add		36.60	4.9	
R585	Tendon repair—flexor—single	3	160.90	21.5	4
E581	—each additional, add		65.80	8.8	
U.V.C.	Mallet finger—closed		visit fee		
R574	—K-wire		73.10	9.8	4
R573	—open	3	109.70	14.6	4
U.V.C.	Boutonniere—closed		visit fee		
R577	—open	3	109.70	14.6	4
R582	—late	3	182.80	24.4	4
	Reconstruction—Extremities				
R602	Pollicization	6	438.75	58.5	6
R603	Digital reimplantation involving microvascular and neuro anastomosis	8	1177.50	157.0	8
R604	Revision of R602, R603	I.C.	I.C.	–	I.C.
R605	Reconstruction and plastic repair of traumatically amputated extremities	I.C.	I.C.	–	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	**HAND and WRIST**–Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
	Release–Tendon				
R575	Tenolysis–**flexor or extensor tendons of one digit**	**3**	**$146.25**	**19.5**	**4**
E537	**--each additional digit (max. 2), add**		**65.80**	**8.8**	
	Tenotomy or fasciotomy (closed) (I.O.P.)				
Z247	–finger–one		36.60	4.9	4
Z248	–two		54.90	7.3	4
Z249	–three or more		73.10	9.8	4
Z231	–palmar or plantar		54.90	7.3	4
R536	Tendon release (open)–finger/palm		73.10	9.8	4
R537	–wrist	3	95.10	12.7	4
E571	–more than one, add		65.80	8.8	
	Reduction–Fractures				
F004	Phalanx–no reduction, rigid immobilization		36.60	4.9	
F005	–closed		73.10	9.8	4
E558	–each additional		18.30	2.4	
F007	–open	4	109.70	14.6	4
F008	Metacarpal–no reduction, one or more, rigid immobilization		36.60	4.9	
F009	–closed, one or more		73.10	9.8	4
F011	–open	4	109.70	14.6	4
E559	–each additional add, (open)		36.60	4.9	
F006	Intra-articular–closed		58.50	7.8	
F010	–open	3	109.70	14.6	4
F012	Bennett's–no reduction, rigid immobilization		36.60	4.9	
F013	–closed	3	73.10	9.8	4
F015	–open	4	146.25	19.5	4
F102	Carpus–no reduction, rigid immobilization		36.60	4.9	
F016	–closed, one or more		73.10	9.8	4
F017	–open, one or more	4	146.25	19.5	4
F018	Scaphoid–no reduction, rigid immobilization		36.60	4.9	
F019	–open	4	182.80	24.4	4
F020	–excision	4	146.25	19.5	4
	Reduction--Dislocations				
D001	Finger–closed–one		36.60	4.9	4
E576	–each additional, add		7.30	1.0	
D003	–open	3	109.70	14.6	4
D004	Metacarpal/phalangeal–closed--one		36.60	4.9	4
E577	–each additional, add		7.30	1.0	
D006	–open	3	109.70	14.6	4
D007	Carpal--closed		91.40	12.2	4
D008	–open	3	146.25	19.5	4
	ELBOW and FOREARM				
	Amputation				
R613	Through radius and ulna	4	219.40	29.2	5
R614	Elbow disarticulation	4	219.40	29.2	5
	Arthrodesis				
R466	Elbow	3	292.50	39.0	4
	Arthroplasty				
R281	Ulna replacement (lower end)	3	182.80	24.4	4
R288	Implant radial head	3	153.60	20.5	4
R499	Removal of total replacement	3	292.50	39.0	7
R486	Complete arthroplasty replacement	6	402.20	53.6	8
R510	Interposition arthroplasty	6	329.10	43.9	7
E564	Revision of elbow arthroplasty, add 35%				

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	**ELBOW and FOREARM**–Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Arthroscopy				
Z218	Arthroscopy		$ 73.10	9.8	4
E595	Preceding surgery		47.55	6.3	
	Arthrotomy				
R445	Elbow, loose body, etc.	3	128.00	17.1	4
	Aspiration/Injection–see page 47				
	Biopsy				
Z225	Bone–needle (I.O.P.)		54.90	7.3	4
Z214	–open (I.O.P.)		109.70	14.6	4
E563	Joint–via arthroscope		7.30	1.0	
R432	–open	3	128.00	17.1	4
Z228	Muscle/soft tissue (I.O.P.)		73.10	9.8	4
	Decompression/Denervation				
R495	Fasciotomy for compartment syndrome (not including secondary closure wound)	3	146.25	19.5	4
Z783	**Secondary closure**		73.10	9.8	
Z251	Catheter–insertion (I.O.P.)		36.60	4.9	
	–monitoring		visit fees		
N285	Exploration and/or decompression and/or transposition and/or neurolysis of ulnar nerve (elbow)	4	157.50	21.0	4
R426	Denervation–elbow	3	182.80	24.4	4
	Drainage				
R228	Acute, incision and drainage	3	182.80	24.4	4
R231	Sequestrectomy	3	219.40	29.2	4
R229	Saucerization and bone grafting	3	329.10	43.9	4
Z226	Soft tissue or bursa, incision and drainage		73.10	9.8	4
R445	Elbow, incision and drainage	3	128.00	17.1	4
	Examination/Manipulation				
Z222	Manipulation under general anæsthetic (I.O.P.)		18.30	2.4	4
	–without general anæsthetic, see page 52				
	Excision–Bone				
R287	Radial head	3	146.25	19.5	4
R286	Radial styloid	3	146.25	19.5	4
R643	Ulna lower end	3	146.25	19.5	4
R290	Olecranon	3	146.25	19.5	4
R291	Olecranon with fascial repair	3	182.80	24.4	4
	Excision–Bursæ				
R595	Olecranon	3	76.80	10.2	4
	Excision–Joint Contents				
R421	Synovectomy/capsulectomy/debridement, etc.	3	255.90	34.1	4
	Excision–Muscles				
R524	Myositis ossificans	4	219.40	29.2	5
R517	Foreign body removal		29.25	3.9	4
	Excision–Tumours				
R522	Soft tissues–superficial		I.C.	–	I.C.
R523	–deep		I.C.	–	I.C.
	Excision–Bone Tumours				
R294	Exostosis	4	109.70	14.6	4
R295	Simple excision	4	219.40	29.2	4
R293	Extensive with replacement	4	511.90	68.2	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM—Cont'd.

Code	ELBOW and FOREARM—Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Reconstruction—Bone—Pseudoarthrosis				
R323	Radius or ulna	3	$219.40	29.2	4
R473	Radius and ulna	3	310.80	41.4	4
	Reconstruction—Bone—Osteotomy				
R259	Radius, ulna	3	219.40	29.2	4
R324	Radius, ulna, and reconstruction congenital abnormality, synotosis, etc.	3	329.10	43.9	4
	Reconstruction—Fascia				
R476	Repair fascial defects—small	3	109.70	14.6	4
R478	—large with or without synthetic graft or rotation flap	4	219.40	29.2	5
	Reconstruction—Ligaments				
R597	Simple/single repair	3	146.25	19.5	4
R548	Extensive/multiple repair	3	329.10	43.9	4
	Reconstruction—Tendons				
R578	Suture extensor tendon—single	3	95.10	12.7	4
E580	—each additional, add		36.60	4.9	
R585	Suture flexor tendon—single	3	160.90	21.5	4
E581	—each, additional, add		65.80	8.8	
R557	Tenoplasty—single	3	146.25	19.5	4
E050	—each additional, add		65.80	8.8	
R556	Tenolysis—single	3	146.25	19.5	4
E599	—each additional, **(max. 2)** add		65.80	8.8	
R563	Transposition/transplantation/transfer—single	3	219.40	29.2	4
E054	—each additional, add		65.80	8.8	1 (max.)
R583	Steindler flexoplasty	3	255.90	34.1	5
	Release				
R519	Muscles and tendons—simple, e.g. tennis elbow	4	73.10	9.8	4
R521	—radical, e.g. muscle slide	5	219.40	29.2	5
	Reduction—Dislocations				
D009	Elbow joint—closed reduction		51.20	6.8	4
D010	—open reduction—acute	3	146.25	19.5	4
R400	—repair chronic, recurrent	3	255.90	34.1	4
D012	Radial head—closed reduction, pulled elbow		29.25	3.9	4
D011	—open reduction—acute	3	146.25	19.5	4
R540	—recurrent	3	182.80	24.4	6
R558	—late	4	292.50	39.0	6
	Reduction—Fractures				
F029	Epicondyle—no reduction		51.20	6.8	
F037	—closed reduction	3	80.40	10.7	4
F038	—open reduction	4	128.00	17.1	4
F039	Transcondylar/condylar—no reduction		51.20	6.8	
F040	—closed reduction	3	146.25	19.5	4
F041	—open reduction	4	255.90	34.1	4
F034	Olecranon—no reduction, rigid immobilization		51.20	6.8	4
F035	—closed reduction	3	80.40	10.7	4
F036	—open reduction	4	146.25	19.5	4
F024	Radius and ulnar shaft—no reduction, rigid immobilization		51.20	6.8	
F025	—closed reduction	3	109.70	14.6	4
F026	—open reduction	4	277.90	37.1	4
F014	Radius and ulna—Monteggia—no reduction, rigid immobilization		51.20	6.8	
F022	—closed reduction		109.70	14.6	4
F023	—open reduction of ulna plus closed reduction radial head	3	153.60	20.5	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	ELBOW and FOREARM–Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
F031	Radius or ulna–no reduction, rigid immobilization		$ 51.20	6.8	
F032	–closed reduction	3	80.40	10.7	4
F033	–open reduction	4	146.25	19.5	4
	Radius-distal, Colles', Smith's, Barton's, etc.				
F027	–no reduction, rigid immobilization		51.20	6.8	
F028	–closed reduction	3	80.40	10.7	4
F030	–open reduction	4	146.25	19.5	4
F021	Osteochondral–open reduction	4	190.10	25.3	5
	SHOULDER/ARM/CHEST				
	Amputation				
R617	Forequarter	10	365.60	48.8	15
R616	Shoulder disarticulation	9	292.50	39.0	9
R615	High humerus	4	219.40	29.2	5
	Arthrodesis				
R467	Shoulder	4	365.60	48.8	6
	Arthroplasty				
R438	Humeral prosthesis	4	365.60	48.8	6
R487	Total prosthesis	6	585.00	78.0	10
R498	Removal prosthesis/no replacement	3	292.50	39.0	8
E564	Revision of prosthesis, add 35%				
	Arthroscopy				
Z218	Arthroscopy (I.O.P.)		73.10	9.8	4
E595	Preceding surgery (same surgeon)		47.55	6.3	
	Arthrotomy				
R411	Shoulder	4	146.25	19.5	4
	Aspiration/Injection–see page 47				
	Biopsy				
Z220	Bones–needle/punch, x-ray control (I.O.P.)		54.90	7.3	4
Z214	–open (I.O.P.)	4	109.70	14.6	4
E563	Joint–via arthroscope		7.30	1.0	
R411	–open	4	146.25	19.5	4
Z228	Soft tissue–open (I.O.P.)		73.10	9.8	4
	Drainage				
R222	Humerus/clavicle/scapula–incision and drainage	4	146.25	19.5	4
R225	Sequestrectomy	4	219.40	29.2	4
R223	Saucerization with bone graft	4	329.10	43.9	4
Z226	Bursae/soft tissue		73.10	9.8	4
R411	Joint	4	146.25	19.5	4
	Examination and Manipulation				
Z223	Manipulation under general anæsthetic (I.O.P)		36.60	4.9	4
	–without general anaesthetic, see page 52				
	Excision–Clavicle or Acromium				
R298	Simple (includes ligament)	4	146.25	19.5	4
R641	Major tumour	I.C.	219.40	29.2	I.C. by Region
R214	Malignant tumour with reconstruction	I.C.	365.60	48.8	
	Excision–Humerus				
R292	Head	4	219.40	29.2	5
R294	Exostosis	4	109.70	14.6	4
R295	Benign tumour	4	219.40	29.2	4
R297	Malignant tumour with reconstruction	4	585.00	78.0	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	SHOULDER/ARM/CHEST–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Excision–Joint				
R422	Synovectomy and debridement	4	$365.60	48.8	5
R512	Excision of subacromial bursae	3	146.25	19.5	4
R522	Muscle/fascia–simple		I.C.	–	I.C.
R523	–complex		I.C.	–	I.C.
R416	**Rotator cuff exploration (includes acromioplasty, excision of coraco-acromial ligament)**	4	146.25	19.5	4
R490	Acromio/sterno-clavicular meniscectomy	3	146.25	19.5	4
	Reconstruction–Pseudoarthrosis and Osteotomy				
R329	Pseudoarthrosis–clavicle	4	182.80	24.4	4
R325	–humerus	4	219.40	29.2	4
R260	Osteotomy–humerus	4	219.40	29.2	4
R298	–clavicle	4	146.25	19.5	4
R235	–glenoid	4	219.40	29.2	4
	Reconstruction–Nerves–see page 126				
	Reconstruction–Muscles/Soft Tissues				
R527	Muscle transplant–pectoralis major	6	255.90	34.1	6
R521	Muscle/tendon release	5	219.40	29.2	5
R526	Release–sternomastoid	5	219.40	29.2	5
R353	Scapuloplexy–congenital elevation	6	292.50	39.0	6
R568	Trapezius/sternomastoid/transplant	4	255.90	34.1	4
R589	Tendon repair–biceps	3	146.25	19.5	4
R593	**Rotator cuff repair–simple, end-to-end or side-to-side (includes acromioplasty, excision of coraco-acromial ligament)**	**4**	**219.40**	**29.2**	**5**
R594	**Rotator cuff repair–complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, excision of distal clavicle)**	**4**	**365.60**	**48.8**	**5**
	Reduction–Fractures				
F047	Tuberosity–no reduction		51.20	6.8	
F048	–closed reduction	3	91.40	12.2	4
F049	–open reduction (without cuff tear)	4	219.40	29.2	4
F053	Neck without dislocation of head–no reduction		51.20	6.8	
F054	–closed reduction		91.40	12.2	4
F055	–open reduction	5	219.40	29.2	6
F050	Neck with dislocation of head–no reduction		51.20	6.8	
F051	–closed reduction	3	138.90	18.5	4
F052	–open reduction	5	255.90	34.1	6
F042	Shaft–no reduction		51.20	6.8	
F043	–closed reduction	3	109.70	14.6	4
F044	–open reduction	4	219.40	29.2	4
U.V.C.	Clavicle–no reduction		visit fees		
F110	–closed reduction with anaesthetic	3	47.55	6.3	4
F118	–open reduction	4	146.25	19.5	4
F119	Scapula–no reduction		51.20	6.8	
F120	–closed reduction with anaesthetic	3	87.75	11.7	4
F121	–open reduction	4	182.80	24.4	5
F122	Sternum–no reduction		51.20	6.8	
F123	–closed reduction		87.75	11.7	
F124	–open reduction–pleura open	9	I.C.	–	13
F125	–pleura closed	4	I.C.	–	4
U.V.C.	Ribs–no reduction		visit fees		
F130	–complicated–pleura open	9	I.C.	–	13
F131	–pleura closed	4	I.C.	–	4
	Reduction–Dislocations				
D014	Acromio-clav./sterno-clav.–no reduction		51.20	6.8	
D025	–closed with anaesthetic	4	109.70	14.6	4
D023	–open reduction	4	146.25	19.5	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	SHOULDER/ARM/CHEST–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anaes-thetist
R596	–open reduction–late	4	$ 219.40	29.2	4
	Glenohumeral joint–closed reduction				
D015	–without anaesthetic		36.60	4.9	
D016	–with anaesthetic		73.10	9.8	4
D017	–open reduction–early	4	219.40	29.2	6
R472	–late	4	438.75	58.5	7
R401	–recurrent	5	292.50	39.0	5
	SKULL and MANDIBLE				
	Arthroplasty				
R433	Temporo-mandibular joint–unilateral	5	255.90	34.1	5
	Biopsy (I.O.P.)				
Z869	Bones–punch, simple		29.25	3.9	4
Z870	–punch, x-ray control		73.10	9.8	4
Z242	–open	4	146.25	19.5	4
	Drainage				
Z234	**Mandibular sequestrectomy (I.O.P.)**	7	206.25	27.5	7
	Excision				
R272	Bone–Tumour	I.C.	I.C.	–	I.C.
R278	Maxilla, with exenteration of orbit and skin graft	4	390.00	52.0	7
R279	Maxilla advancement	4	322.50	43.0	8
R280	Mandible	4	258.75	34.5	7
R284	Mandibular condyle	4	202.50	27.0	5
R428	**Temporo-mandibular meniscectomy**	**3**	**182.80**	**24.4**	**5**
	Reconstruction				
R531	Facial paralysis–static slings	4	225.00	30.0	5
R532	–dynamic slings	4	292.50	39.0	6
R533	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	4	375.00	50.0	7
E597	–with meloplasty, add		63.75	8.5	
	Orthognathic Surgery				
	Anterior dento-alveolar osteotomy, maxilla or mandible				
R382	**–one segment**	**6**	**588.75**	**78.5**	**10**
R383	**–two segments**	**6**	**682.50**	**91.0**	**10**
	Posterior dento-alveolar osteotomy, maxilla				
R349	**–one side**	**6**	**588.75**	**78.5**	**10**
R351	**–both sides, single segment**	**6**	**682.50**	**91.0**	**10**
R385	**–both sides, separate segments**	**6**	**870.00**	**116.0**	**10**
	Posterior dento-alveolar osteotomy, mandible				
R462	**–one side**	**6**	**588.75**	**78.5**	**10**
R463	**–both sides**	**6**	**870.00**	**116.0**	**10**
R502	**Total U dento-alveolar osteotomy, mandible**	**6**	**900.00**	**120.0**	**10**
R507	**Total U dento-alveolar osteotomy, maxilla**	**6**	**963.75**	**128.5**	**10**
R511	**Mandibular or maxillary visor osteotomy for aveolar hypoplasia**	**6**	**840.00**	**112.0**	**10**
R386	**Genioplasty–one segment**	**6**	**187.50**	**25.0**	**10**
R387	**–two segments, or for laterognathia**	**6**	**281.25**	**37.5**	**10**
R388	**–three segments**	**6**	**375.00**	**50.0**	**10**
R480	**Mandibular osteotomies for prognathism–subcondylar**	**3**	**307.50**	**41.0**	**6**
R384	**–vertical ramus**	**6**	**682.50**	**91.0**	**10**
R518	**–sagittal split**	**6**	**682.50**	**91.0**	**10**
	Mandibular osteotomies for retrognathia, any technique				
R520	**–advancement up to 10 mm**	**6**	**682.50**	**91.0**	**10**
R529	**–advancement 10 - 20 mm**	**6**	**776.25**	**103.5**	**10**
R535	**–advancement greater than 20 mm**	**6**	**993.75**	**132.5**	**10**
E588	**–for apertognathia or laterognathia, add**		**187.50**	**25.0**	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	SKULL and MANDIBLE–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
R379	Le Fort I advancement–in one segment	10	$ 588.75	78.5	20
E961	–in two segments, add		217.50	29.0	
E962	–in three segments, add		435.00	58.0	
R538	Le Fort I intrusion–in one segment	10	776.25	103.5	20
E963	–in two segments, add		217.50	29.0	
E964	–in three segments, add		435.00	58.0	
R567	Le Fort I extrusion–in one segment*	10	963.75	128.5	20
E965	–in two segments, add		217.50	29.0	
E966	–in three segments, add		435.00	58.0	
R580	Le Fort I in cleft patient–in one segment*	10	1,117.50	149.0	20
E967	–in two segments, add		187.50	25.0	
E968	–in three segments, add		375.00	50.0	
E969	–with SMR, add		150.00	20.0	
E970	–with pharyngoplasty, add		225.00	30.0	
E971	–with closure alveolar fistula with or without bone graft, add		281.25	37.5	
E972	–with closure hard palate fistula with or without bone graft, add		375.00	50.0	
R588	Naso-maxillary osteotomy without Le Fort I*	6	588.75	78.5	10
R389	Le Fort II maxillary osteotomy and advancement*	10	1,057.50	141.0	20
R395	Construction glenoid fossa and zygomatic arch* (Obwegeser technique)	10	1,027.50	137.0	20
R396	Construction absent condyle and ascending ramus*	6	588.75	78.5	10
R609	Combined Le Fort I and Le Fort III osteotomy in hemifacial microsomia	10	1,117.50	149.0	20
R145	Mandibular condylotomy	4	150.00	20.0	5
R618	Coronoidotomy	4	150.00	20.0	5
R644	Coronoidectomy	4	225.00	30.0	5
	Reconstruction unilateral mandible with bone grafts*				
R334	–partial	4	300.00	40.0	10
R335	–complete	4	600.00	80.0	10
	Reconstruction bilateral mandible with bone grafts*				
R645	–partial	4	600.00	80.0	10
R646	–complete	4	750.00	100.0	10
R647	Oral vestibuloplasty–with secondary epithelization	4	150.00	20.0	5
R648	–with skin graft	4	225.00	30.0	5
	Temporomandibular ankylosis				
R649	–excision bone or fibrous block	3	337.50	45.0	6
R650	–with insertion of prosthetic device or muscle flap	4	375.00	50.0	8
R651	–with construction of condyle and ascending ramus*	4	487.50	65.0	10
	Onlay bone grafts to face when not part of standard osteotomy for reconstruction*				
Z253	–mandible–unilateral		262.50	35.0	
Z254	–bilateral		337.50	45.0	
Z255	–maxilla–unilateral		262.50	35.0	
Z256	–bilateral		337.50	45.0	
Z257	–zygoma–unilateral		225.00	30.0	
Z258	–bilateral		300.00	40.0	
Z259	–temporal–unilateral		300.00	40.0	
Z260	–bilateral		375.00	50.0	
Z261	–frontal–unilateral		300.00	40.0	
Z262	–bilateral		375.00	50.0	
	Application of dental arch bars, or splint, for facial osteotomy (I.O.P.)				
Z239	–one arch bar	4	97.50	13.0	4
Z240	–two arch bars	4	150.00	20.0	4
R354	Interdental wiring for temporomandibular joint disorder	3	112.50	15.0	5
R652	Removal intermaxillary fixation devices under general anaesthesia –as sole procedure		75.00	10.0	4

*Includes harvesting of bone or cartilage grafts.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	SKULL and MANDIBLE–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Orbito-cranial Surgery				
R390	Bilateral periorbital correction Treacher-Collins Syndrome with or without bone grafts* (extra-cranial)	10	$1,245.00	166.0	20
R653	Bilateral periorbital correction Treacher-Collins Syndrome with skull and muscle transpositions* (includes skull reconstruction) (intra-cranial)	10	1,586.25	211.5	25
R654	Pericranial flap to orbit or face–unilateral		225.00	30.0	4
R655	–bilateral		300.00	40.0	4
	–when in conjunction with coronal approach for main operation				
E973	–unilateral		131.25	17.5	
E974	–bilateral		217.50	29.0	
R378	Le Fort III total maxillary advancement*	12	1,492.50	199.0	25
R656	Le Fort III and subcranial hypertelorism correction*	12	1,897.50	253.0	25
R657	Le Fort III and Le Fort I maxillary advancement*	12	1,710.00	228.0	25
R658	Le Fort II, subcranial hypertelorism correction, Le Fort I maxillary advancement*	12	2,145.00	286.0	30
	Upper Le Fort III advancement without occlusal change*				
R659	–unilateral	6	682.50	91.0	10
R675	–bilateral	12	1,057.50	141.0	25
R676	Forehead advancement (bone grafts not included)–unilateral	12	870.00	116.0	25
R393	–bilateral	12	1,057.50	141.0	25
R394	Cranial vault reshaping*–anterior or posterior half	10	1,117.50	149.0	20
R677	Total cranial vault reshaping*	12	1,522.50	203.0	25
R398	Medial transnasal canthopexy–unilateral	3	300.00	40.0	6
E557	–when done in conjunction with another procedure		112.50	15.0	
R399	Lateral transnasal canthoplasty–unilateral	3	150.00	20.0	6
E930	–when done in conjunction with another procedure		75.00	10.0	
R376	Hypertelorism correction, intracranial approach*	12	1,710.00	228.0	25
R377	Hypertelorism correction, subcranial U osteotomies*	12	1,428.75	190.5	25
R678	Hypertelorism correction, medial orbital wall osteotomies*	10	900.00	120.0	20
R679	Hypertelorism correction, medial and lateral orbital wall osteotomies*	10	1,181.25	157.5	20
R391	Orbital dystopia*–intracranial approach	12	1,428.75	190.5	25
R392	–extracranial approach	10	1,087.50	145.0	20
	Late correction traumatic enophthalmos (Tessier Technique–total periorbital stripping and bone grafts)				
R680	–intracranial	12	1,462.50	195.0	25
R681	–extracranial	10	1,057.50	141.0	20
	Harvesting of bone graft when not included				
Z263	–iliac bone graft		75.00	10.0	
Z264	–rib graft–one rib		112.50	15.0	
E975	–each subsequent rib		56.25	7.5	
Z265	–costochondral or chondral graft–one rib		168.75	22.5	
E976	–each subsequent rib		112.50	15.0	
Z266	–split cranial graft		150.00	20.0	
	Surgery for Correction of Down's Syndrome Facial Stigmata				
	Augmentation of zygoma (bilateral)				
Z267	–with prosthetic implant		135.00	18.0	
Z268	–with autogenous bone or cartilage*		168.75	22.5	
	Augmentation of chin				
Z269	–with prosthetic implant		112.50	15.0	
Z270	–with autogenous bone or cartilage*		138.75	18.5	
Z271	Horizontal resection, red lower lip		135.00	18.0	

***Includes harvesting of bone or cartilage grafts**

Code	SKULL and MANDIBLE–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Reduction–Fractures				
	Orbit				
	Open reduction rim/wall fracture				
E173	–zygomatic fracture dislocation	4	202.50	27.0	6
E174	–blowout fracture of floor	4	236.25	31.5	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM—Cont'd.

Code	SKULL and MANDIBLE—Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
E175	—secondary repair by combined or orbital approach	4	$ 348.75	46.5	6
F143	Middle 1/3 facial	5	315.00	42.0	6
F144	Cranial-facial separation	5	397.50	53.0	8
	Nasal bones (including septum)				
U.V.C.	—no reduction		visit fees		
F136	—closed reduction		75.00	10.0	4
F137	—open reduction		187.50	25.0	5
	Mandible				
U.V.C.	—no reduction—no wiring of teeth		visit fees		
F138	—closed reduction—including wiring of teeth		187.50	25.0	5
	—open reduction (may include wiring of teeth)				
F139	—one side	4	251.25	33.5	5
F146	—complicated	I.C.	I.C.	–	I.C.
F140	—removal of interdental wire				4
	Maxilla				
U.V.C.	—no reduction		visit fees		
F150	—closed reduction and dental wiring		187.50	25.0	5
F141	open reduction—simple	4	108.75	14.5	5
F142	—with wiring and local fixation	5	288.75	38.5	6
	Reduction—Dislocations				
D062	Temporo-mandibular joint—closed reduction		37.50	5.0	4
D063	—open reduction	5	187.50	25.0	5
	SPINE				
	Arthrodesis				
R459	Anterior or posterior fusion of one level	7	292.50	39.0	10
R419	Fusion of C1-2	8	380.25	50.7	10
E573	Each additional level (to a max. of 2 additional)		73.10	9.8	
	Fusion with other procedure(s)				
E567	By same surgeon—one level, add		195.00	26.0	
E568	—multiple levels, add		255.00	34.0	
E929	—anterior cervical interbody fusion, per level, add		60.00	8.0	
	Fusion by different surgeon,				
R493	—one level		232.50	31.0	
R494	—multiple levels		273.75	36.5	
E924	—anterior cervical interbody fusion, per level, **add**		90.00	12.0	
E574	Repeat fusion, to any fusion, **not apply to N337, add**		176.25	23.5	
E548	With instrumentation, add		116.25	15.5	
	Aspiration/Injection—see pages 37 and 47				
	Biopsy				
Z868	Bone—needle (I.O.P.)	4	109.70	14.6	4
R274	—open—posterior approach	4	182.80	24.4	7
R275	—anterior approach	6	234.00	31.2	8
Z228	Soft tissue—open (I.O.P.)		73.10	9.8	4
	Decompression—Anterior, Anterolateral or Posterolateral				
R447	Simple anterior cervical discectomy	8	273.75	36.5	10
R452	Simple anterior lumbar discectomy	6	390.00	52.0	10
N182	Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level	8	450.00	60.0	10
N186	Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level	9	817.50	109.0	13
	For thoracotomy or laparotomy by separate surgeon use M137 (page 91), S312 (page 108)				
E928	Each additional disc level decompressed—to R447, R452, N182, N186, add		195.00	26.0	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	**SPINE**–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Decompression–Posterior				
R451	Cervical hemilaminectomy for disc disease, with or without foraminotomy	6	$431.25	57.5	10
R457	Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	6	315.00	42.0	8
E565	Multiple levels, to R451, R457, **only** per additional level, add		60.00	8.0	
E566	Bilateral, to R451, R457 add		60.00	8.0	
N185	Posterior laminectomy one or two levels, cervical, thoracic, lumbar	6	450.00	60.0	9
N337	Repeat posterior **exploration** or reopening of posterior **exploration,** more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	8	487.50	65.0	10
E914	Laminectomy extending over 3 or more laminae, to N185, N337 add		116.25	15.5	
E915	Foraminotomy, to R457, N185 and N337 per foramen decompressed, add		60.00	8.0	
E907	Opening of dura (associated with any decompressive procedure), add		116.25	15.5	
E926	Spinal duroplasty (applies to any spinal procedure), add		176.25	23.5	
	Drainage				
R251	Bone–incision and drainage only	4	219.40	29.2	4
R234	Sequestrectomy–anterior	7	475.30	63.4	10
R254	–posterior	4	292.50	39.0	4
R270	Saucerization with bone grafting–anterior	6	585.00	78.0	10
R252	–posterior	4	292.50	39.0	5
Z226	Soft tissue		73.10	9.8	4
	Examination/Manipulation				
Z215	Manipulation under general anæsthetic (I.O.P.)		29.25	3.9	4
	–without general anæsthetic, see page 52				
	Excision–Bone				
R373	Spinous process	4	182.80	24.4	4
R374	Lamina or transverse process	6	292.50	39.0	8
R450	Part of body or pedicle	6	438.75	58.5	8
R455	Total body (includes replacement)	9	731.25	97.5	13
	Excision–Muscle/Soft Tissue				
R634	Tumours–simple		I.C.	–	I.C.
R635	–complex		I.C.	–	I.C.
	Reconstruction–Osteotomy (includes fixation/fusion)				
R303	Anterior–via chest	9	585.00	78.0	13
R636	–via abdomen	9	585.00	78.0	9
R271	–via chest and abdomen	9	658.10	87.8	13
R296	Posterior	9	548.40	73.1	9
E549	–with rib or transverse release, add		95.10	12.7	
R310	Circumferential	9	877.50	117.0	9
R264	Cervical	10	877.50	117.0	12
	Instrumentation–Deformities				
	Anterior (Dwyer etc. includes fusion/disectomy)				
R350	–via chest or abdomen	9	1,096.90	146.2	17
R359	–via chest and abdomen	9	1,206.60	160.9	17
R362	Posterior (Harrington)–with **or without** fusion	8	592.30	79.0	12
E533	**Harrington instrumentation to sacrum or pelvis, add**		**58.50**	**7.8**	
E534	**Harrington instrumentation, for each level over 6, add**		**14.60**	**1.9**	
E554	–with posterior osteotomy, add		109.70	14.6	
R371	Luque procedure–with fusion	8	914.10	121.9	12
E535	**Luque instrumentation to pelvis, add**		**109.70**	**14.6**	
E536	**Luque instrumentation, for each level over 6, add**		**21.90**	**2.9**	
R369	Readjustment of instrumentation		109.70	14.6	4
R461	Removal of–anterior instrumentation	8	219.40	29.2	8
R348	–posterior instrumentation	8	146.25	19.5	8

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	SPINE–Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Revision of entire instrumentation				
R346	–with fusion	8	$ 914.10	121.9	12
R336	–without fusion	8	731.25	97.5	12
R365	Electrical stimulation	8	438.75	58.5	10
R366	–with muscle stripping of spine	8	548.40	73.1	12
R367	Repair or replacement of electrodes	8	146.25	19.5	10
R368	Removal of electrodes	8	146.25	19.5	8
R464	Muscle stripping spine prior to surgery	6	146.25	19.5	8
R361	Halo traction prior to surgery (complete care)	3	219.40	29.2	4
	Anterior release including Halo traction				
R358	–via chest or abdomen	9	438.75	58.5	13
R357	–via chest and abdomen	9	511.90	68.2	13
R356	Localizer cast		73.10	9.8	4
	Reduction–Fractures or Fracture Dislocations				
U.V.C.	Fracture of spine without procedure		visit fees		
Z236	Skull calipers (I.O.P.)		37.50	5.0	
Z241	Halo traction (I.O.P.)		60.00	8.0	
Z246	Reapplication of Halo traction (I.O.P.)		37.50	5.0	
E562	Counter traction pins or vest–add		78.75	10.5	
F103	Closed reduction	5	138.75	18.5	5
F105	Open reduction–posterior approach	5	232.50	31.0	5
F107	–anterior approach	5	273.75	36.5	10
E913	With spinal cord injury, add (when total care by operating surgeon)		116.25	15.5	
E927	With irrigation, including opening of dura, to fractures when combined with decompressive procedures, add		232.50	31.0	
E567	Fusion by same surgeon–one level, add		195.00	26.0	
E568	–two or more levels, add		255.00	34.0	
	Fusion by different surgeon				
R493	–one level, add		232.50	31.0	
R494	–two or more levels, add		273.75	36.5	
E548	With instrumentation, add		116.25	15.5	
	PELVIS and HIP				
	Amputation				
R631	Hemipelvectomy–hindquarter	10	585.00	78.0	15
R630	Hip disarticulation	10	365.60	48.8	10
	Arthrodesis				
R469	Sacro-iliac joint	5	292.50	39.0	5
R514	Symphysis pubis	5	292.50	39.0	6
R470	Hip	5	585.00	78.0	8
	Arthroplasty				
R439	Unipolar	6	365.60	48.8	8
R440	Bipolar	8	585.00	78.0	8
R442	Surface replacement	8	731.25	97.5	8
E589	Bone graft to acetabulum, add		73.10	9.8	
E593	Acetabular reconstruction (extensive, including bone grafts), add		146.25	19.5	
E564	Revision, add 35%				2
R481	Reattachment of greater trochanter (late)	6	219.40	29.2	8
R443	Removal only–non cemented	3	292.50	39.0	8
R488	–cemented	3	365.60	48.8	8
	Arthroscopy				
Z218	Hip joint (I.O.P.)		73.10	9.8	4
E595	Preceding surgery (same surgeon)		47.55	6.3	
	Arthrotomy				
R547	Sacro-iliac joint	5	219.40	29.2	6
R415	Hip–with removal of loose body	5	219.40	29.2	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	PELVIS and HIP–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anaes-thetist
	Aspiration/Injection–see pages 37, 47				
	Biopsy				
Z212	Bone–punch needle (I.O.P.)		$ 54.90	7.3	
Z217	–under general anaesthetic (I.O.P.)		54.90	7.3	5
Z214	–open (I.O.P.)		109.70	14.6	4
E563	Joint–via arthroscope		7.30	1.0	
R415	–open	5	219.40	29.2	6
Z228	Soft tissue–open		73.10	9.8	4
	Denervation/Decompression				
N293	Decompression of lateral femoral cutaneous nerve	4	116.25	15.5	4
N179	Exploration and/or decompression of sciatic nerve	6	330.00	44.0	6
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve	4	157.50	21.0	4
N284	Decompression by excision of first rib and/or cervical rib to include scalenotomy when required	6	292.50	39.0	6
R427	Denervation of hip	4	292.50	39.0	5
N294	**Division, obturator nerves**	**6**	**135.00**	**18.0**	**6**
	Drainage				
R269	Bone, incision and drainage	3	219.40	29.2	4
R249	Sequestrectomy	4	292.50	39.0	4
R250	Saucerization and bone graft	4	511.90	68.2	5
Z226	Bursae/soft tissue (I.O.P.)		73.10	9.8	4
R415	Joint	5	219.40	29.2	6
	Examination/Manipulation				
Z252	Manipulation–under general anaesthetic		29.25	3.9	4
	–without general anaesthetic, see page 52				
	Excision–Bone				
R639	Simple cyst, etc.	4	255.90	34.1	4
R330	Major resection tumour	4	365.60	48.8	6
R216	Radical resection tumour	8	585.00	78.0	8
F115	Coccyx	4	146.25	19.5	4
R315	Head and neck, femur	4	365.60	48.8	6
	Excision–Muscle				
R522	Simple		I.C.	–	I.C.
R523	Complex		I.C.	–	I.C.
R524	Myositis	4	219.40	29.2	5
	Excision–Joint				
R423	Synovectomy/debridement	5	402.20	53.6	5
	Excision–Bursae				
R590	GT trochanteric/ischial	3	146.25	19.5	4
	Reconstruction–Pseudoarthrosis				
R364	Pelvis	I.C.	438.75	58.5	I.C.
R328	Hip	6	365.60	48.8	6
	Reconstruction–Osteotomy				
R265	Pelvis–infant	8	292.50	39.0	8
R273	–other	8	438.75	58.5	8
R263	Hip	5	438.75	58.5	7
	Reconstruction–Muscle/Tendon				
R521	Muscle release	5	219.40	29.2	5
Z232	Closed adductors–tenotomy (I.O.P.)		36.60	4.9	4
Z233	Open adductors–tenotomy (I.O.P.)		73.10	9.8	4
R545	Iliopsoas–tenotomy	5	182.80	24.4	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	PELVIS and HIP–Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Reconstruction–Tendon Transfer				
R570	Iliopsoas	5	$ 438.75	58.5	6
R569	Abductor	5	292.50	39.0	6
	Reduction–Fractures				
U.V.C.	Coccyx–no reduction		visit fees		
F115	–excision	4	146.25	19.5	4
U.V.C.	Pelvic ring–no reduction		visit fees		
F134	–closed reduction	3	365.60	48.8	4
F135	–open reduction	6	511.90	68.2	8
U.V.C.	Sacrum–no reduction		visit fees		
U.V.C.	Femoral neck–no reduction		visit fees		
F098	–closed reduction/traction	3	292.50	39.0	4
F099	–open reduction–pin only	6	292.50	39.0	8
F100	–pin and plate	6	402.20	53.6	8
F101	–primary prosthesis	6	329.10	43.9	8
R600	–delayed/staged graft	6	219.40	29.2	8
	Slipped epiphysis				
R607	–closed reduction/traction	6	292.50	39.0	8
R642	–closed reduction/internal fixation	6	292.50	39.0	8
R627	–open reduction/fixation	6	438.75	58.5	8
	Reduction–Disclocations				
U.V.C.	Acetabulum–no reduction		visit fees		
D052	–open reduction–lips	7	365.60	48.8	8
D046	–one pillar	4	731.25	97.5	10
D047	–two pillars	8	1,096.90	146.2	12
D042	Hip–closed		219.40	29.2	4
D043	–open	7	292.50	39.0	7
R628	–late	7	585.00	78.0	10
D059	Sacro-iliac–closed, traction, spica, etc.		365.60	48.8	5
D060	–open	5	511.90	68.2	5
U.V.C.	Sacro-coccygeal–closed		visit fees		
D061	–open, removal of coccyx	5	146.25	19.5	5
R404	Congenital hip–closed (includes tenotomy and cast)		146.25	19.5	4
R405	–repeat (includes cast)		73.10	9.8	4
R406	–open (includes tenotomy and arthrotomy)	7	292.50	39.0	7
	FEMUR				
	Amputation				
R625	Gritti-Stokes or Callander	5	219.40	29.2	5
R626	Through femur	5	219.40	29.2	5
	Biopsy (I.O.P.)				
Z869	Bone–core, punch		29.25	3.9	4
Z870	–x-ray control/general anæsthetic		73.10	9.8	4
Z242	–open	4	146.25	19.5	4
Z228	Soft tissue–open		73.10	9.8	4
	Drainage				
R242	Incision and drainage, bone	3	219.40	29.2	4
R245	Sequestrectomy	3	292.50	39.0	4
R243	Saucerization and graft	5	511.90	68.2	6
Z226	Soft tissue		73.10	9.8	4
	Excision–Bone				
R314	Simple cyst/exostosis	4	182.80	24.4	4
R330	Bone tumour–simple	4	365.60	48.8	6
R216	–with construction/graft	8	585.00	78.0	8

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM–Cont'd.

Code	FEMUR–Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
	Excision–Muscle				
R522	Simple		I.C.	–	I.C.
R523	Complex		I.C.	–	I.C.
R328	**Reconstruction–Pseudoarthrosis**	6	$365.60	48.8	6
	Reconstruction–Fascial				
R632	Simple	3	146.25	19.5	4
R633	Complex with or without synthetic graft or rotation flap	4	292.50	39.0	5
	Reconstruction–Osteotomy				
R262	Femoral shaft	4	438.75	58.5	5
R215	Supracondylar	4	292.50	39.0	6
	Reconstruction–Leg Length Operations				
R333	Femoral shortening–all types	4	365.60	48.8	4
R332	Femoral lengthening–all types	4	365.60	48.8	4
R340	Femoral epiphysiodesis	4	219.40	29.2	5
R341	Tibial and femoral epiphysiodesis	4	329.10	43.9	5
R343	Femoral stapling	4	182.80	24.4	4
R344	Tibial and femoral stapling	4	292.50	39.0	5
	Reconstruction–Muscles/Tendons				
R589	Quadriceps repair–simple	3	146.25	19.5	4
R587	–reconstructive	3	292.50	39.0	4
R530	Quadricepsplasty–all types	4	292.50	39.0	5
R561	Ilio-tibial band	3	117.00	15.6	4
Z197	**Closed release of ilio-tibial band (I.O.P)**		**36.60**	**4.9**	4
R543	Tenotomy of hamstrings–single	3	91.40	12.2	4
R562	–multiple	3	109.70	14.6	4
R557	Lengthening of hamstrings–single	3	146.25	19.5	4
E050	–each additional, add		65.80	8.8	
R571	Tendon or muscle transfer	3	219.40	29.2	5
E049	–each additional, add		65.80	8.8	1 (max.
R524	Excision of myositis	4	219.40	29.2	5
	Reduction–Fractures				
	Femoral shaft/supracondylar				
U.V.C.	–no reduction–cast–bed rest		visit fee	–	
F093	–closed reduction–traction–infant		146.25	19.5	4
F094	–child	3	182.80	24.4	4
F095	–adult or adolescent	3	292.50	39.0	4
F096	–open reduction	6	365.60	48.8	8
	KNEE				
	Amputation				
R625	Through knee–disarticulation	5	219.40	29.2	5
	Arthrodesis				
R468	Knee	3	292.50	39.0	5
	Arthroplasty				
R509	Patellar arthroplasty	3	182.80	24.4	5
	Hemi-arthroplasty				
R482	–single component (e.g. MacIntosh)	6	219.40	29.2	6
R483	–double component (e.g. Marmar)	6	329.10	43.9	6
R441	Total replacement/both compartments	8	511.90	68.2	8
E598	With associated patellar replacement or patelloplasty, add		73.10	9.8	
	Removal of hemi-arthroplasty				
R496	–without replacement	4	182.80	24.4	5
	Removal of total arthroplasty				
R497	–without replacement	4	237.70	31.7	5
E564	Revision of arthroplasty, add 35%				

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM—Cont'd.

Code	KNEE—Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Arthroscopy				
Z218	Diagnostic arthroscopy		$ 73.10	9.8	4
E595	Preceding surgery of joint		47.55	6.3	
	Arthrotomy				
R412	Knee—**with or without removal of loose body**	3	146.25	19.5	4
R413	Osteochondritis dessicans with drilling and/or internal fixation	3	190.10	25.3	4
	Aspiration—see listing on page 47				
	Biopsy				
Z870	Bone/joint—needle (I.O.P.)		73.10	9.8	4
Z242	—open (I.O.P.)	4	146.25	19.5	4
E563	—via arthroscope		7.30	1.0	
Z228	Soft tissue—open (I.O.P.)		73.10	9.8	4
	Denervation/Decompression				
R426	Denervation of knee	3	182.80	24.4	4
N296	Denervation of gastrocnemius	4	131.60	17.5	4
	Drainage				
Z226	Soft Tissue (I.O.P.)		73.10	9.8	4
R444	Joint	3	146.25	19.5	4
	Examination/Manipulation				
Z222	Manipulation—under general anæsthetic (I.O.P.)		18.30	2.4	4
	—without general anæsthetic, see page 52				
	Excision				
R431	Baker's cyst—simple	3	95.10	12.7	4
R434	—extensive	4	182.80	24.4	6
R501	Cysts of meniscus	3	95.10	12.7	4
R429	Meniscectomy	3	182.80	24.4	4
R417	Debridement of joint without synovectomy	3	219.40	29.2	4
R424	Synovectomy	3	365.60	48.8	5
R506	Prepatellar bursae	3	95.10	12.7	4
R312	Patella—**to include fascial repair**	3	219.40	29.2	4
R318	**Excision exostosis/cyst patella**	**3**	**95.10**	**12.7**	**4**
	Reconstruction—Meniscus				
R508	Suturing of **medial or lateral meniscus**	3	182.80	24.4	5
	Reconstruction—Muscles/Tendons				
R584	Tenoplasty—one	3	109.70	14.6	4
E050	—each additional, add		65.80	8.8	
R589	Suture of patellar or quadriceps tendon—early	3	146.25	19.5	4
R587	—late	3	292.50	39.0	4
R571	Transplant of tendon—single	3	219.40	29.2	5
E049	—each additional, add		65.80	8.8	1 (max.)
Z237	Tenotomy—closed—one		36.60	4.9	4
Z238	—multiple		54.90	7.3	4
R564	—open—one	3	73.10	9.8	4
R566	—multiple	3	109.70	14.6	4
R516	Release patellar retinaculum	5	109.70	14.6	5
	Reconstruction—Ligaments				
R599	Ligaments—simple/one	3	277.90	37.0	4
R542	—extensive/multiple (including synthetics)	4	424.10	56.6	6
R484	— synthetic anterior/posterior cruciate	6	365.60	48.8	6
R539	—removal of synthetics	4	182.80	24.4	4
	Reduction—Fractures				
F085	Patella—no reduction		51.20	6.8	
F087	**—open reduction or excision with or without repair**	4	219.40	29.2	4
F021	Osteochondral fracture—open reduction	4	190.10	25.4	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	KNEE–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Reduction–Dislocations				
D038	Knee–closed reduction		$ 146.25	19.5	4
D039	–open reduction	5	219.40	29.2	5
D040	Patella–closed reduction–without anæsthetic		43.90	5.9	
D031	–with anæsthetic		73.10	9.8	4
D041	–open reduction–early		219.40	29.2	5
R255	–late	4	365.60	48.8	6
R403	–recurrent	4	292.50	39.0	5
R515	Congenital dislocation–knee (open)	4	365.60	48.8	6
	FIBULA and TIBIA				
	Amputation				
P624	Tibia/fibula	5	219.40	29.2	5
	Biopsy (I.O.P.)				
Z870	Bone–simple–punch		73.10	9.8	4
Z242	–open	4	146.25	19.5	4
Z228	Soft tissue–open		73.10	9.8	4
	Decompression/Denervation				
R495	Decompression of fascial compartments	3	146.25	19.5	4
Z783	**Secondary closure**		**73.10**	**9.8**	
Z251	Catheter insertion (I.O.P.)		36.60	4.9	
U.V.C.	Monitoring of pressure monitoring device		visit fees		
N184	Decompression of posterior tibial or common perineal nerve	4	124.30	16.6	4
	Drainage				
R237	Incision and drainage, bone	3	182.80	24.4	4
R239	Sequestrectomy	3	219.40	29.2	4
R238	Saucerization and bone grafting	3	329.10	43.9	4
Z226	Soft tissue		73.10	9.8	4
	Excision				
R311	Exostosis/cyst	3	146.25	19.5	4
R210	Fibular head	3	146.25	19.5	4
R295	Tumour–simple	4	219.40	29.2	4
R253	–extensive with repair	I.C.	511.90	68.2	I.C.
R522	Muscle/soft tissue–simple		I.C.	–	I.C.
R523	–complex		I.C.	–	I.C.
	Reconstruction–Pseudoarthrosis				
R326	Tibia/fibula	4	255.90	34.1	5
R327	By-pass fibular graft	4	292.50	39.0	6
R372	Congenital pseudoarthrosis	4	365.60	48.8	6
	Reconstructive–Osteotomy				
R289	**Tibia and fibula – adult or child**	**3**	**292.50**	**39.0**	4
R403	Tuberosity (Macquet)	4	292.50	39.0	5
	Reconstruction–Leg Length Operations				
R331	Tibial lengthening	4	292.50	39.0	4
R458	Tibial shortening	4	292.50	39.0	4
R341	Tibial and femoral epiphysiodesis	4	329.10	43.9	5
R339	Tibial epiphysiodesis	4	219.40	29.2	5
R342	Tibial stapling–one side	4	146.25	19.5	4
R460	–both sides	4	182.80	24.4	4
R344	Tibial and femoral stapling	4	292.50	39.0	5
	Reduction–Fractures				
	Tibia with or without fibula				
F078	–no reduction, rigid immobilization		87.75	11.7	
F079	–closed reduction	3	146.25	19.5	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	**FIBULA AND TIBIA**–Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
F080	–open reduction–shaft	4	$ 255.90	34.1	5
F081	**–medial or lateral tibial plateau**	4	292.50	39.0	5
E532	**–both tibial plateaus, same knee, add 50%**				
F082	Fibula–no reduction, rigid immobilization		51.20	6.8	
F083	–closed reduction		73.10	9.8	4
F084	– open reduction	4	128.00	17.1	4
	FOOT and ANKLE				
	Amputation				
R620	Metatarsal/phalynx disarticulation	4	109.70	14.6	4
E585	–each additional		36.60	4.9	
R621	Ray (single)	4	164.55	21.9	4
R623	Symes	5	219.40	29.2	5
R622	Transmetatarsal/transtarsal	4	164.55	21.9	4
R619	Terminal Symes	4	109.70	14.6	4
	Arthrodesis				
R466	Ankle	3	292.50	39.0	4
R471	Interphalangeal	3	109.70	14.6	4
E575	–each additional		29.25	3.9	
R477	Metatarsophalyngeal	3	186.50	24.9	4
R474	Midtarsal/subtalar	3	255.90	34.1	4
R513	Triple	3	292.50	39.0	5
R475	Pan-talar, one stage	3	541.10	72.1	6
	Arthroplasty				
R485	Ankle–total replacement	6	329.10	43.9	6
R479	Removal of prosthesis without replacement	3	146.25	19.5	6
	Metatarsophalyngeal interposition				
R456	–single	3	109.70	14.6	5
E538	–each additional, add		29.25	3.9	
R453	Metatarsophalyngeal (Swansons, etc.)	3	219.40	29.2	5
R454	–multiple	3	292.50	39.0	6
R500	Removal–prosthesis without replacement	3	109.70	14.6	4
E564	Revision of arthroplasty, add 35%				
	Arthroscopy				
Z218	Ankle without surgery		73.10	9.8	4
Z219	Other foot joints		47.55	6.3	4
E595	Ankle followed by surgery		47.55	6.3	
E630	Other foot joints with surgery		47.55	6.3	
	Arthrotomy				
R503	Ankle–removal of loose body, etc.	3	128.00	17.1	4
E539	–with osteotomy of malleolus, add		91.40	12.2	
R504	Mid tarsals	3	109.70	14.6	4
R505	Metatarsal/phalangeal	3	109.70	14.6	4
	Aspiration–see listings on page 47				
	Biopsy				
Z869	Bone–needle–punch (I.O.P.)		29.25	3.9	4
Z870	–punch–under general anæsthetic		73.10	9.8	4
Z242	–open	4	146.25	19.5	4
E563	Joint–via arthroscope		7.30	1.0	
R409	–open		109.70	14.6	4
Z228	Soft tissue–open (I.O.P.)		73.10	9.8	4
	Drainage				
R220	Incision and drainage–bone	3	98.70	13.2	4
R201	Sequestrectomy	4	146.25	19.5	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	FOOT AND ANKLE–Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
R202	Saucerization and bone graft	4	$ 292.50	39.0	4
Z226	Bursae (I.O.P.)		73.10	9.8	4
R503	Joints	3	128.00	17.1	4
Z228	Soft tissue (I.O.P.)		73.10	9.8	4
	Examination/Manipulation				
Z222	–under general anæsthetic		18.30	2.4	
	–without general anæsthetic, see page 52				
	Club foot, etc.–manipulation and cast/strapping				
Z235	–without anæsthetic		14.60	2.0	
Z224	–with anæsthetic		29.25	3.9	4
	Excision–Bone				
R299	Phalanx	3	80.40	10.7	4
R309	Metatarsal head	3	109.70	14.6	4
E587	–each additional		29.25	3.9	
R305	Accessory navicular (scaphoid)	3	95.10	12.7	4
R302	Bunion/bunionette	3	95.10	12.7	4
R307	Calcaneal spur	3	91.40	12.2	4
R282	Exostosis (dorsal, subungual)	3	54.90	7.3	4
R308	Os calcis, talus	3	219.40	29.2	4
R301	Sesamoid, one or both	3	91.40	12.2	4
R306	Tarsal bar	3	164.55	21.9	4
R272	Tumour (foot)	I.C.	I.C.	–	I.C.
R300	Tumour (phalanx)–simple	3	146.25	19.5	4
R272	–complex	I.C.	I.C.	–	I.C.
	Excision–Joint				
R420	Ankle synovectomy	3	219.40	29.2	4
R425	Metatarsophalangeal synovectomy–one	3	182.80	24.4	4
R414	–two or more	3	292.50	39.0	4
	Excision–Soft Tissue				
R549	Ganglion–simple	3	73.10	9.8	4
R553	–complex	3	I.C.	–	4
R506	Bursa	3	95.10	12.7	4
R551	Fascia (Dupytrens)–partial	3	146.25	19.5	4
R552	–complete	3	292.50	39.0	5
R522	Muscle–simple		I.C.	–	I.C.
R523	–complex		I.C.	–	I.C.
	Reconstruction–Pseudoarthrosis				
R363	Malleoli	3	190.10	25.3	4
R321	Tarsals/metatarsals/phalanx	3	182.80	24.4	4
	Reconstruction–Osteotomy				
R259	Os calcis	3	219.40	29.2	4
R276	Metatarsals and phalanx	3	109.70	14.6	4
E596	–each additional		29.25	3.9	
R277	Midtarsal/tarsal	3	182.80	24.4	4
R337	Shortening metatarsal–one	4	146.25	19.5	4
R338	–two or more	4	182.80	24.4	4
	Reconstruction–Forefoot				
R430	Claw and hammer toe	3	102.40	13.6	4
E594	–each additional hammer toe, add		29.25	3.9	
R304	Hallus Valgus–Mayo, Keller	3	146.25	19.5	4
R355	–Joplin, McBride	3	201.10	26.8	4
R360	Major forefoot reconstruction–max.	3	292.50	39.0	5
R446	Overlapping 5th toe	3	102.40	13.6	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM–Cont'd.

Code	FOOT AND ANKLE–Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Reconstruction–Club Foot				
R408	Posterior or medial release	4	$ 219.40	29.2	4
R448	Posteromedial release, lateral shortening, tendon transfers and fusion	4	292.50	39.0	4
R546	Plantar fascia release (Steindler)	3	73.10	9.8	4
	Reconstruction–Ligaments				
R597	Ankle–one	3	146.25	19.5	4
R548	–extensive/multiple	3	329.10	43.9	4
	Reconstruction–Tendons				
R640	Exploration–tendon sheath	3	95.10	12.7	4
	Tenolysis–extensive release				
R556	–one	3	146.25	19.5	4
E599	–each additional digit (max. 2), add		65.80	8.8	
	Tendon transfer foot and ankle				
R565	–single	3	182.80	24.4	4
E055	–each additional, add		65.70	8.8	1 (max.)
R572	Tenodesis	3	182.80	24.4	4
R560	Graft	4	182.80	24.4	4
E053	–each additional, add		65.80	8.8	
R557	Lengthening or shortening–one	3	146.25	19.5	4
E050	–each additional, add		65.80	8.8	
R578	Suture extensor tendon–one	3	95.10	12.7	4
E580	–each additional		36.60	4.9	
R585	Suture flexor tendon–one	3	160.90	21.5	4
E581	–each additional, add		65.80	8.8	
R589	Achilles tendon repair–early	3	146.25	19.5	4
R587	–late	3	292.50	39.0	4
R579	Tenotomy (open)–one toe		65.80	8.8	4
R581	–more than one toe		146.25	19.5	4
Z229	(closed)–one toe (I.O.P.)		36.60	4.9	4
Z243	–more than one toe (I.O.P.)		73.10	9.8	4
	Achilles or tibialis anterior/posterior				
R544	tenotomy–open	3	73.10	9.8	4
R555	–closed		36.60	4.9	4
	Reduction–Fractures				
F074	Ankle–no reduction, rigid immobilization		51.20	6.8	
F075	–closed reduction	3	109.70	14.6	4
F076	–open–one malleolus	4	164.55	21.9	4
F077	–multiple malleoli or ligaments	4	219.40	29.2	5
	Ankle fracture with tibial Plafond burst				
F104	–closed	3	182.80	24.4	4
F108	–open	4	274.20	36.6	6
	Metatarsus–no reduction				
F061	–one or more		36.60	4.9	
F062	–with rigid immobilization		51.20	6.8	
F063	–closed reduction–one or more	3	65.80	8.8	4
F064	–open reduction–one	4	91.40	12.2	4
F065	–two or more	4	164.55	21.9	4
F070	Os calcis–no reduction–rigid immobilization		73.10	9.8	
F071	–closed reduction		91.40	12.2	4
F072	–open reduction	4	182.80	24.4	4
	Phalanx–no reduction				
F056	–rigid immobilization–one		36.60	4.9	
E560	–each additional		7.30	1.0	
F058	–closed reduction–one		43.90	5.8	4
E561	–each additional		11.25	1.5	
F060	–open reduction	4	91.40	12.2	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTERY SYSTEM—Cont'd.

Code	FOOT AND ANKLE—Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Tarsus excluding os calcis				
F066	—no reduction—rigid immobilization		$ 73.10	9.8	
F067	—closed reduction	3	91.40	12.2	4
F068	—open reduction	4	164.55	21.9	4
	Intra-articular fracture—I.P. joint				
F057	—closed reduction		58.50	7.8	
F059	—open reduction	3	109.70	14.6	4
	Reduction—Dislocations				
D035	Ankle—closed reduction		65.80	8.8	4
D036	—open reduction	4	146.25	19.5	4
R402	—recurrent **dislocation and/or subluxation**	4	292.50	39.0	5
D027	Interphalangeal—closed		36.60	4.9	4
E578	—each additional		7.30	1.0	
D029	—open	4	91.40	12.2	4
D030	Metatarsophalangeal—closed		36.60	4.9	4
E579	—each additional		7.30	1.0	
D032	—open	4	91.40	12.2	4
D033	Tarsus—closed		91.40	12.2	4
D034	—open	4	164.55	21.9	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	NOSE	Assistant	Surgeon	Anæsthetist
	Nasopharynx			
Z298	E.U.G.A. of nasopharynx **for malignant disease including biopsies (not to be charged if done in conjunction with T & A, adenoidectomy or quadroscopy** (I.O.P.)		$ 30.00	4
R181	**Excision of nasopharyngeal lesion with palatal split**	**4**	**375.00**	**7**
R182	**Excision of nasopharyngeal lesion with mandibulotomy, glossotomy and/or palatal split**	**7**	**731.25**	**10**
	Fiberoptic endoscopy of upper airway (nose, hypopharynx or larynx) (I.O.P.)			
Z296	–if only **operative** procedure performed		11.60	
Z297	Insertion of prosthesis for nasal septal perforation (I.O.P.)		13.10	
	Incision (I.O.P.)			
Z301	Drainage of abscess or hæmatoma		41.25	4
Z302	Turbinate reduction–uni or bilateral (to include cautery, cryosurgery, turbinectomy		41.25	4
	Excision			
Z304	Nasal polyp (I.O.P.)–single		15.00	
Z305	–multiple or involving general anæsthetic (unilateral)		41.25	4
Z308	Choanal polypectomy (I.O.P.)–unilateral		41.25	4
Z309	Biopsy (I.O.P.)–single		13.10	
Z310	–multiple or involving general anæsthetic		37.50	4
Z311	Removal of foreign body (I.O.P.)–simple		7.50	
Z312	–complicated, or involving general anæsthetic		37.50	4
M010	Excision of intranasal **lesions by lateral rhinotomy approach**	4	356.25	7
M011	Excision of other intranasal lesions	I.C.	I.C.	I.C.
	Reconstruction			
M012	Septoplasty **(when antrum lavage, polypectomy, turbinate reduction, intranasal ethmoidectomies or antrostomies are done in addition, add 50% of the appropriate fees to M012)**		187.50	4
M013	Partial septorhinoplasty (excluding osteotomies)		266.25	7
M014	Septorhinoplasty		356.25	7
M019	–with autologous bone or cartilage graft	3	562.50	7
M024	–with non-autologous graft or implant	4	450.00	7
R319	Graft to nose–autologous, bone or cartilage (without septorhinoplasty)	4	266.25	4
R320	–non-autologous or prosthetic implant (without septorhinoplasty)	4	172.50	4
M015	Septodermoplasty (to include fascial and other grafts)		225.00	4
M016	Repair of septal perforation		225.00	4
M017	**Packing for** localization of cerebrospinal rhinorrhea		26.25	4
E603	**–with fluorescein injection, add**		**37.50**	
M018	Endonasal augmentation for atrophic rhinitis–unilateral (including obtaining graft or preparing implant)		225.00	4
M020	Repair of choanal atresia–uni or bilateral	4	266.25	4
M021	Puncture and insertion of tube for choanal atresia–uni or bilateral		67.50	4
M028	Dilation of choanal atresia–uni or bilateral		30.00	4
	Rhinoplasty for reconstruction of cleft lip – nasal deformity (not to be billed with repair of cleft lip)			
M030	–complex, to include necessary grafts and septoplasty	4	450.00	7
M031	–tip and septum reconstruction only		187.50	4
	Treatment of Epistaxis (Nasal Hæmorrhage)			
Z314	Cauterization (I.O.P.)–unilateral		8.25	4
Z315	Anterior packing (I.O.P.)–unilateral		11.25	4
Z316	Posterior packing (I.O.P.)–uni or bilateral		26.25	4
M027	Ligation of external carotid artery–unilateral	6	150.00	6
R788	**Ligation of internal maxillary artery–unilateral**	**7**	**300.00**	**10**
R789	**Ligation of anterior artery ethmoidal–unilateral**	**6**	**150.00**	**6**

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM–Cont'd.

Code	NOSE–Cont'd.	Assistant	Surgeon	Anæsthetist
	ACCESSORY NASAL SINUSES			
	Antrum or sinus lavage (I.O.P.)			
Z319	Antral puncture and/or lavage – uni or bilateral		$ 31.10	4
M054	Maxillary, intranasal antrostomy–unilateral	4	90.00	4
	Maxillary, Caldwell-Luc (intranasal antrostomy included)			
M055	–unilateral	4	165.00	4
M056	Maxillectomy–partial or complete	7	562.50	10
E947	–with orbital exenteration, add		225.00	
Z318	Frontal trephine or sinusotomy **(I.O.P.)**		97.50	4
M058	Radical frontal sinusectomy		337.50	5
M063	**Coronal and/or osteoplastic procedure for frontal sinusectomy, reconstruction or obliteration–unilateral or bilateral**	7	562.50	10
	External frontal-ethmoidal sinusectomy and/or reconstruction			
M059	–unilateral	4	337.50	6
M060	Intranasal ethmoidectomy–unilateral		108.75	4
M023	External or **transantral** ethmoidectomy–unilateral (to include Caldwell-Luc with transantral approach)	4	266.25	4
M061	Trans-septal sphenoidotomy or sphenoid sinusectomy		262.50	4
M064	External transethmoidol sphenoidotomy or sphenoid sinusectomy	7	450.00	10
M062	Vidian neurectomy–unilateral	4	337.50	4
M066	Closure of antral fistula–minor		45.00	4
M067	–complex or involving general anæsthetic (to include Caldwell-Luc if necessary)		255.00	5
	LARYNX			
	Endoscopies (I.O.P.)			
	Laryngoscopy:			
Z321	Direct–with or without biopsy		45.00	6
Z322	–with removal of foreign body		78.75	6
Z323	–with removal of lesion(s)		108.75	6
Z343	–with dilatation of larynx, to include bronchoscopy if necessary		150.00	6
Z324	Indirect–with biopsy **or removal of foreign body**		26.25	6
E600	Using operating microscope– add to charges for laryngoscopy		26.25	
	Introduction			
M080	Teflon augmentation larynx		135.00	6
	Excision (to include laryngoscopy)			
M081	Laryngectomy–total	6	525.00	13
E882	**–with hemi thyroidectomy, add**		**129.40**	
E883	**–with subtotal thyroidectomy, add**		**195.00**	
E884	**–with total thyroidectomy, add**		**273.75**	
M082	Laryngofissure	6	225.00	8
M084	Laryngectomy–segmental, including reconstruction	6	637.50	9
M085	Arytenoidectomy or arytenoidopexy or lateralization procedure	6	266.25	8
	Repair (to include laryngoscopy)			
M090	Laryngoplasty–e.g. repair of stenosis and fractures, transections–**not to be billed with M084**		637.50	6
M089	Creation of tracheo-œsophageal fistula	3	112.50	4
Z320	Insertion of voice prosthesis (I.O.P.)		18.75	
Z303	Removal of laryngeal stent or keel		75.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM–Cont'd.

TRACHEA AND BRONCHI

Preamble:

(1) When laryngoscopy and bronchoscopy or œsophago-bronchoscopy are carried out as combined procedures, the physician should claim for one or the other but not both.

(2) No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anæsthetic by the same surgeon.

Code	TRACHEA AND BRONCHI	Assistant	Surgeon	Anæsthetist
	Endoscopy (I.O.P.)			
	Bronchoscopy			
Z327	–with or without bronchial biopsy, suction or injection of contrast material		$ 82.50	6
Z328	–with removal of foreign body		131.25	6
Z350	–with dilatation of stricture		116.25	6
Z351	–with selective endobronchial blocker or catheter insertion		116.25	6
Z352	–with palliative endobronchial tumour resection including laser or cryotherapy		131.25	
Z313	**–with broncho alveolar lavage for obtaining specimens suitable for differential cellular analysis (for assessment of interstitial lung disease)**		**116.25**	**6**
Z342	**–with brushings and/or biopsy from each lobe; specimens labelled as to site**		**135.00**	**6**
Z349	–with transbronchial lung biopsy under image intensification only		123.75	6
E622	–any bronchoscopic procedure for patients under 2 years of age, add		58.10	
Z359	**Repeat bronchoscopy for tracheobronchial toilet when performed within one week of another bronchoscopic procedure**		**37.50**	**6**
Z355	Quadroscopy or panendoscopy–with or without biopsy (nasopharyngoscopy, laryngoscopy, bronchoscopy, œsophagoscopy **with or without gastroduodenscopy**), using separate instruments in search of malignant disease,		135.00	6
	Tracheo-bronchial aspiration (I.O.P.)			
Z344	First procedure		27.20	
Z345	Subsequent procedures performed by same physician		13.50	
	(Not to apply to (1) operating surgeons, (2) when respiratory unit fees apply, or (3) within the first two hours post-operatively.)			
Z326	Change of tracheostomy tube		8.25	
Z346	Transtracheal aspiration		16.30	
Z356	Closure of persistent tracheostoma		97.50	
	Incision (I.O.P.)			
Z741	Tracheotomy	3	112.50	6
Z738	**Insertion of Montgomery "T" Tube or similar laryngeol or tracheal stent**	4	150.00	8
	Excision			
M099	**Segmental** resection of cervical trachea	9	573.75	10
E631	**–with resection of cricoid, add**		**225.00**	
M103	Segmental resection of trachea with either sternotomy or thoracotomy	9	922.50	13
M104	Carinal resection (without pulmonary resection)	11	592.50	15
E623	Re-operation after 30 days, add		296.25	
	Repair			
M100	Tracheal rupture, transcervical	9	468.75	10
M101	Tracheal-bronchial rupture, transthoracic	9	618.75	13

CHEST WALL AND MEDIASTINUM

Code	Description	Assistant	Surgeon	Anæsthetist
	Excision			
M105	Chest wall tumour, resection of 2 or 3 ribs or cartilages	9	367.50	13
E601	–for each additional rib (more than 3) to a maximum of 3 additional, add		40.90	

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM–Cont'd.

Code	**CHEST WALL AND MEDIASTINUM**–Cont'd.	Assistant	Surgeon	Anæsthetist
E602	–with sternal resection, add		$123.75	
M107	Total sternectomy	9	536.25	13
N284	Excision of first rib and/or cervical rib to include scanelotomy when required	6	292.50	6
M106	Mediastinal tumour	9	461.25	13
M108	**Ligation of thoracic duct–as sole procedure**	**6**	**292.50**	**6**
	Repair			
	Chest wall			
M109	pleura–closed		I.C.	5
M110	–open		I.C.	13
M116	Chest wall fixation for trauma	4	258.75	6
E604	–for fixation of each additional rib exceeding four ribs, add		40.90	2
M117	Sternal fixation for trauma	4	186.40	6
R352	Pectus excavatum or carinatum repair (by reconstruction, not implant)	6	495.00	11
	Surgical Collapse			
M111	Thoracoplasty–one stage	9	225.00	10
E605	–for each additional rib (more than 3) to a maximum of 3 additional, add		40.90	
Z742	Phrenicotomy (I.O P.)	3	75.00	5
	Incision			
Z353	Incisional biopsy of chest wall tumour (I.O.P.)	3	66.00	4
Z354	Excisional biopsy of rib for tumour (I.O.P.)	4	99.00	6
Z357	Thoracic window creation (I.O.P.)	5	155.25	7
Z358	Thoracic window closure (I.O.P.)	4	77.60	6
	Endoscopies (I.O.P.)			
Z329	Mediastinoscopy		135.00	6
Z330	–with bronchoscopy		178.50	6
Z333	–with transbronchial biopsy under image intensification (including bronchoscopy)		198.00	6
Z348	–with bronchoscopy and mediastinotomy	3	251.25	6
Z347	Anterior mediastinotomy–when sole procedure performed	3	142.50	6
	LUNGS AND PLEURA			
	Introduction–Thoracentesis (I.O.P.)			
Z331	Aspiration for diagnostic sample		18.00	
Z332	Aspiration with therapeutic drainage with or without diagnostic sample		32.80	4
E606	Administration of chemotherapy or sclerosing agent, add		7.90	
Z334	Total unilateral lung lavage with or without bronchoscopy using double lumen tube and single lung anæsthesia		210.00	13
	Endoscopy (I.O.P.)			
Z335	Thoracoscopy (pleuroscopy) with or without pleural biopsy, suction, etc.		78.75	5
	Incision			
Z340	Biopsy of lung, needle (I.O.P.)		54.40	4
Z336	Biopsy of pleura, needle (I.O.P.) – including diagnostic aspiration		31.90	4
Z341	Closed drainage effusion or pneumothorax, (I.O.P.)		45.00	4
E606	–with administration of chemotherapy or sclerosing agent		7.90	
Z337	Rib resection for drainage (I.O.P.)	6	90.00	6
M133	Thoracotomy for removal of foreign body	9	279.40	13
M137	Thoracotomy with or without biopsy	9	279.40	13
M134	Thoracotomy for post-operative hæmorrhage or empyema	9	279.40	13
M132	Thoracotomy with repair of ruptured diaphragm	9	360.00	13

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM–Cont'd.

Code	LUNG AND PLEURA–Cont'd.	Assistant	Surgeon	Anaesthetist
M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal)	9	$ 391.90	13
E609	–with intercostal muscle bundle, add		90.00	
E610	–with myovascular flap (pectoralis major, latissimus dorsi, rectus abdominus), add		195.00	
M135	Major decortication of lung for empyema or tumour	11	393.75	15
Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia (I.O.P.)	4	135.00	6
	Excision			
Z338	Biopsy of pleura or lung – with limited thoracotomy (I.O.P.)	9	146.25	13
M138	Hilar lymphnode or lung biopsy with full thoracotomy	9	296.25	13
M142	Pneumonectomy with or without radical mediastinal node dissection or pericardial resection requiring repair	10	682.50	14
E612	–total extra-pleural pneumonectomy, add		86.25	
E613	–sleeve pneumonectomy, add		178.50	
E614	–omental graft, add		120.00	
E615	–intra-pericardial dissection, add		58.10	
E611	**–with resection of diaphragm including reconstruction**		**86.25**	
M143	Lobectomy with or without radical mediastinal node dissection	10	682.50	13
E616	–bi-lobectomy on right side, add		101.25	
E617	–with pleural tent, add		58.10	
E618	–with decortication of remaining lobe(s)		86.25	2
E619	–sleeve lobectomy, add		120.00	
E620	–with wedge bronchoplasty, add		58.10	
E611	**–with resection of diaphragm including reconstruction**		**86.25**	
E621	–with diagnostic wedge resection		30.00	
E624	–with completion pneumonectomy for positive resection margin, add		78.75	
E625	–with sleeve resection of pulmonary artery, add		101.25	
M144	Segmental resection, including segmental bronchus and artery	10	682.50	13
M145	Wedge resection of lung	10	318.75	13
E608	–each additional (to a maximum of three)		45.00	
M151	Bullectomy for major bullous disease	10	453.75	13
M149	Pleurectomy, and/or apical bullectomy for pneumothorax	10	318.75	13
E607	Re-operation more than 30 days subsequent to previous excision, add to appropriate excision fee		112.50	

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Assistant	Surgeon	Anæsthetist
	(a) with hypothermia and without bypass–basic fee for			
R700	cardiovascular procedures			25
E650	(b) pump bypass–(anæsthetist–see preamble)		$262.50	28
	(bypass includes cannulating and decannulating heart or major vein, major artery, supervision of pump and pump run.)			
	(c) circulatory assist device e.g. intra-aortic balloon (includes cannulation, **repair of artery,** daily care and supervision) (I.O.P.)			
Z743	– open		213.75	5
Z780	– percutaneous		155.25	5
	(d) decannulation of circulatory assist device **(includes repair of artery)** (I.O.P.)			
Z744	– open		86.25	5
Z781	–percutaneous		27.40	
	(e) repositioning of intra-aortic balloon pump (no charge to be made for repositioning within 24 hours of original insertion) (I.O.P)			
Z751	– open		90.00	5
Z782	– percutaneous		58.10	
E655	(f) re-operation for failed vascular grafts–for repair or replacement of existing prosthesis (more than one month after original operation), add to appropriate fee		123.75	
Z759	(g) Removal of failed vascular graft without arterial reconstruction (I.O.P.)–when sole procedure		135.00	6
E658	(h) re-operation involving open heart procedures with pump (more than one month after original operation), add to appropriate fee		165.00	
	(i) Preliminary diagnostic catheterization–extra to operative fees (see Diagnostic and Therapeutic Procedures).			
	(j) The basic anaesthetic fee of 28 units for major cardiovascular surgery includes such procedures as insertion of C.V.P. line (G268), arterial line, blood sampling, blood analysis and interpretations.			

HEART AND PERICARDIUM

Code		Assistant	Surgeon	Anæsthetist
	Cardiac massage			
	–closed (see Resuscitation on page 44)			
R765	–open	13	165.00	13
G295	Insertion of permanent endocardial electrode and implantation of pack, includes insertion of temporary transvenous lead at same surgical procedure by same surgeon		228.75	5
G302	Repositioning of permanent endocardial electrode (as separate procedure)		228.75	5
G269	Insertion of permanent endocardial electrodes(s)		87.00	
G270	Exposure of vein and implantation of pack		120.00	5
G264	Replacement of pack		105.00	5
R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	4	326.25	5
R751	Implantation of epicardial electrode(s) plus implantation of pack	6	333.75	20
Z411	Replacement of pack (I.O.P.)	3	108.75	5
Z412	Replacement or repair of pacemaker lead (I.O.P.)	3	78.75	5
M137	Thoracotomy–with or without biopsy	9	279.40	13
M134	–for post-operative hemorrhage	9	279.40	13
Z401	Aspiration of pericardium (I.O.P.)		93.75	
R750	Open biopsy of pericardium and drainage (transthoracic or epigastric)	13	225.00	13
R748	Pericardiectomy–one side open	13	457.50	20
R749	–both sides open or sternal split	13	727.50	20
R712	Cardiotomy with exploration	18	375.00	20
R713	–with removal of foreign body	18	457.50	20
R714	–with removal of tumour	18	375.00	20

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM–Cont'd.

Code	**HEART AND PERICARDIUM**–Cont'd.	Assistant	Surgeon	Anæsthetist
E660	–electrophysiologic mapping of heart–epicardial		$ 93.75	
E661	–endocardial and/or HIS Bundle		187.50	
E662	–division of accessory conduction pathways		46.90	
R920	Excision–ventricular tumour	18	487.50	28
R746	- ventricular aneurysm	18	630.00	28
R747	–aneurysm of sinus of Valsalva	18	570.00	28
R741	Coronary–endarterectomy	18	532.50	20
E651	–when done in conjunction with coronary artery repair, add		142.50	
E648	**Excision of extensive endocardial scar, add to ventriculotomy or aneurysm repair**		**93.75**	
R742	Coronary artery repair–one	18	648.75	20
R743	–two	18	881.25	20
E654	–each additional		138.75	
	Implantation of internal mammary			
E652	–done in conjunction with coronary artery repair, add		135.00	
R739	–sole procedure–single	18	528.75	20
R740	–double	18	630.00	20
R754	Ligation or division patent ductus–infant or child	13	375.00	20
R755	–adolescent or adult	13	532.50	20
R857	Interruption of bronchial collateral arteries (one or more arteries) – sole procedure	13	532.50	20
E663	– done in conjunction with other cardiac surgery		131.25	
R757	Resection coarctation–infant	13	476.25	20
R756	–child	13	457.50	20
R758	–adolescent or adult	13	585.00	20
R759	Congenital heart procedures–e.g. Blalock, Glenn, Potts, Waterston or Central	13	457.50	20
R763	Creation of ASD–by balloon septostomy	9	225.00	9
R762	–by thoracotomy or Sterling Edwards	18	457.50	20
R715	Closure atrial septal defect: secundum	18	457.50	20
R716	–endocardial cushion and valve defect	18	682.50	20
R717	–with anomalous pulmonary venous drainage	18	577.50	28
R718	Closure of ventricular septal defect	18	577.50	28
	REPAIR			
	Total repair Tetralogy of Fallot			
R720	–with or without previous arterial shunt	18	768.75	28
R722	Total anomalous pulmonary venous drainage	18	682.50	28
R723	Total correction transposition of great vessels	18	682.50	28
R721	Arterial repair of transposition	18	1,023.75	28
R921	Complete A-V canal	18	900.00	28
R922	Single ventricle	18	1,023.75	28
R923	Double outlet–right/left ventricle	18	900.00	28
R924	Double outlet ventricle with transposition	18	1,023.75	28
R925	Truncus arteriosus	18	1,023.75	28
R926	Interrupted aortic arch	18	900.00	28
R927	Aorto-pulmonary window	18	577.50	28
R928	R-V outflow tract with valve and tubular graft	18	645.00	28
R929	Debanding arterioplasty of pulmonary artery	18	573.75	28
R768	Pulmonary artery banding	13	375.00	20
R769	–with pressure studies by anæsthetist, extra/hour			5
R770	Correction of cor triatriatum	18	525.00	20
R771	Vascular ring	18	457.50	20
	VALVES			
R724	Pulmonary valvotomy	18	457.50	28
R725	Pulmonary valvotomy and infundibular resection	18	525.00	28
R772	Pulmonary valve replacement	18	525.00	28

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM–Cont'd.

Code	VALVES–Cont'd.	Assistant	Surgeon	Anæsthetist
R726	Tricuspid valvotomy	18	$ 487.50	20
R727	Tricuspid annuloplasty	18	457.50	20
R728	Tricuspid valve replacement	18	525.00	28
R729	Mitral valvotomy	18	495.00	20
R730	Mitral valvotomy–restenosis	18	551.25	20
R734	Mitral annuloplasty	18	645.00	20
R735	Mitral replacement	18	645.00	28
R930	Aortic valvoloplasty	18	581.25	28
R736	Aortic valvotomy	18	487.50	20
R737	Aortic infundibular resection (ventriculomyotomy)	18	600.00	28
R738	Aortic valve replacement	18	697.50	28
R863	Replacement of aortic valve, replacement of ascending aorta, and reimplantation of coronary arteries (Modified Bentall Procedure)	18	1,477.50	28
	Multivalvular replacement–the fee will be that for the major valve replaced plus 85% of the fee for the additional valve or valves.			
	ARTERIES			
	Cannulation for infusion chemotherapy			
R775	–superficial temporal artery	3	67.50	4
R776	–hepatic artery	6	150.00	6
R778	–carotid	5	105.00	5
R782	Gas embolization of peripheral arteries – complete care		15.00	
R760	Regional isolation perfusion **e.g.** iliac	10	288.75	10
R764	Exploration of major artery	6	193.10	I.C.
	Incision			
Z402	Arteriotomy (I.O.P.)		82.50	4
	Repair – traumatic			
R790	Suture of lacerated major artery	4	225.00	I.C.
R795	Repair of lacerated major artery (including patch angioplasty)	10	352.50	10
R862	–by bypass or interposition graft	10	468.75	10
	Ligation			
R781	Ligation of artery (as sole procedure) –by region etc.*	3	73.10	I.C.*
R788	–internal maxillary artery (Caldwell-Luc approach)	7	300.00	10
R789	–anterior ethmoid artery	6	150.00	6
R708	–internal iliac artery (uni or bilateral)	7	288.75	10
	Excision and/or Repair:			
	Preamble:			
	(1) Repair of arteries implies either endarterectomy and/or bypass graft.			
	(2) Fee for gas endarterectomy of coronary artery should be the same fee as for coronary endarterectomy.			
	(3) The fees listed for by-pass grafts include endarterectomy and/or thrombectomy of the artery being repaired.			
R815	Arterioplasty with or without patch graft **including microvascular anastomosis, arterial and/or venous.** (other than listed below)	10	371.25	10
R792	Carotid–endarterectomy	10	547.50	10
R796	–carotid body tumour	10	547.50	10
R798	–aneurysm–reconstruction or excision with graft	10	581.25	10
	Aortic arch reconstruction			
R830	Innominate	10	611.25	10
R831	Subclavian	10	611.25	10
R832	Vertebral	10	611.25	10
E659	–with thoracotomy, add	3	118.10	7
E667	**–ruptured, add**		187.50	
	Thoracic aorta aneurysm–repair or excision with graft			
R799	–ascending	10	1,027.50	20
R800	–arch	10	1,275.00	20

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM–Cont'd.

Code	**ARTERIES**–Cont'd.	Assistant	Surgeon	Anæsthetist
R801	–descending with or without temporary shunt	10	$ 892.50	20
E667	**–ruptured, add**		187.50	
R803	**Thoraco–abdominal aneurysm**	**18**	**1,725.00**	**25**
R802	Abdominal aorta–aneurysm	10	843.75	17
R816	–plus unilateral common femoral repair	10	918.75	17
R817	–plus bilateral common femoral repair	10	993.75	17
E626	–plus implantation of inferior mesenteric artery, add		123.75	
E627	–ruptured, add		225.00	3
	Mesenteric or celiac artery repair			
R811	–aneurysm	10	288.75	10
R935	–removal of band only	10	288.75	10
R936	–endarterectomy or graft	10	611.25	10
	Aorto-Iliac repair			
R783	–including common iliac repair (uni- or bilateral)	10	712.50	17
R784	–plus unilateral common femoral repair	10	836.25	17
R785	–plus bilateral common femoral repair	10	926.25	17
R814	–embolectomy or thrombectomy of bifurcation (aorta or graft)	10	326.25	10
R858	Total removal of infected aortic graft (stem and limbs) (arterial reconstruction extra)	10	648.75	17
E664	Closure of duodenum, add		90.00	
R859	Partial removal of infected aortic graft (one limb only) (arterial reconstruction extra)	10	243.75	10
R805	Renal artery–aneurysm–reconstruction or excision with graft	10	611.25	10
R806	Renal artery repair	10	611.25	10
R807	Splenic artery aneurysm–reconstruction or excision with graft	10	288.75	10
R786	Iliac repair to include internal iliac aneurysm	10	570.00	10
R937	Ilio-femoral bypass graft	10	570.00	10
R860	Per-obturator ilio-femoral graft – with saphenous vein	10	633.75	10
R861	– with prosthetic graft	10	618.75	10
R855	Common femoral/profunda femoris repair (**profundoplasty**)–when sole procedure performed	10	393.75	10
R856	Extended profundoplasty	10	551.25	10
R933	Axillo-femoral, femoro-femoral or axillo-axillary graft	10	465.00	10
R934	Aorto-femoral unilateral graft	10	611.25	17
R808	Femoral aneurysm–reconstruction or excision with graft	10	423.75	10
R864	Repair of false aneurysm at groin anastomosis	10	630.00	10
R809	Femoral-popliteal endarterectomy	10	536.25	10
	Femoro-popliteal or cross bypass graft, (with or without endarterectomy)			
R791	–with saphenous vein	10	603.75	10
R794	–with prosthetic graft	10	517.50	10
R787	Femoro-ant./post. tibial/peroneal bypass graft (with or without endarterectomy)–with saphenous vein	10	708.75	10
R780	–with prosthetic graft	10	618.75	10
R810	Popliteal aneurysm	7	570.00	10
	Peripheral arteries other than listed			
R812	–aneurysm	7	288.75	10
R813	Embolectomy–artery or graft (**as sole procedure**)	7	228.75	10
R867	Thrombectomy–artery or graft (**as sole procedure**)	7	213.75	10
E649	–when done in conjunction with other vascular repairs, **e.g. R813, R867** add		78.75	
R866	Gastric devascularization–when sole procedure	10	386.25	10
	VEINS			
	Excision			
	Resection of AV aneurysm or fistula with or without major graft			
R825	–major aneurysm by region*	10	690.00	I.C.*
R826	–minor aneurysm etc.	10	352.50	I.C.*

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM—Cont'd.

Code	VEINS—Cont'd.	Assistant	Surgeon	Anæsthetist
	Ligation			
Z745	Saphenous (I.O.P.)		$ 37.50	4
Z746	Femoral (I.O.P.)	3	52.50	4
Z747	Popliteal (I.O.P.)	3	52.50	4
Z748	Internal jugular (I.O.P.)	5	105.00	5
R839	Internal iliac	6	277.50	10
R834	I.V.C.—transabdominal	6	315.00	10
R838	—transvenous	6	213.75	10
R868	**High ligation and stripping of long saphenous vein with groin dissection**	**4**	**105.00**	**4**
R869	**Stripping of short saphenous vein with popliteal dissection**	**4**	**75.00**	**4**
R837	Multiple ligation and avulsion	4	105.00	4
R844	Recurrent varicose veins — multiple ligation and/or stripping	5	251.25	5
R842	Extra fascial and sub-fascial incompetent perforators by full fascial technique	5	270.00	6
E653	—plus stripping, add		90.00	
	Repair			
R820	Lacerated major vein e.g. **femoral, popliteal, vena cava, axillary, subclavian, brachial**	4	225.00	4
R818	**—including patch**	**10**	**352.50**	**10**
R819	**—by vein graft**	**10**	**468.75**	**10**
R835	S.V.C. bypass graft	7	536.25	17
R836	Pulmonary embolectomy	18	611.25	20
R828	Ilio-femoral thrombectomy with or without femoral vein ligation	10	315.00	10
E657	—plus I.V.C. ligation, add		315.00	
R829	Thrombectomy, other than above	I.C.	I.C.	I.C.
R865	Distal spleno-renal shunt	10	892.50	10
	Anastomosis			
R822	Porto-caval	10	648.75	10
R823	Spleno-renal—abdominal approach	10	791.25	10
R821	—transthoracic approach	10	791.25	13
R824	Meso-caval	10	611.25	10
R827	**Creation of A.V. fistula**	**4**	**262.50**	**6**
R841	**Obliteration of A.V. fistula**		**60.00**	**4**
R833	**Ligation or removal of by-pass graft**		**60.00**	**4**

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEMS

Code	SPLEEN AND MARROW	Assistant	Surgeon	Anæsthetist
	Incision (I.O.P.)			
Z404	Splenic puncture and aspiration		$ 58.10	4
Z403	Bone marrow aspiration		24.75	
	Bone marrow interpretation (see **Laboratory medicine**)			
Z408	Bone marrow core biopsy (with biopsy needle)		45.00	4
Z430	Bone marrow transplantation (aspiration from donor and infusion into recipient) – team fee (I.O.P.)	7	408.75	8
	Excision			
R905	Splenectomy – partial or complete	7	348.75	7
	LYMPH CHANNELS			
	Excision			
R907	Cystic hygroma – unilateral	4	247.50	6
	Anastomosis			
R846	Micro lympho-lympho or lymphovenous	7	491.25	7
	LYMPH NODES			
	Incision (I.O.P.)			
Z410	Drainage of sub-fascial abscess		52.90	4
Z413	**Scalene node fine needle aspiration**		**20.90**	
	Excision			
R910	Neck – limited e.g. sub mandibular supra omohyoid	6	195.00	6
R911	– radical	6	431.25	8
R915	– modified radical including functional with preservation of spinal accessory nerve	6	491.25	8
R912	Ileoinguinal, radical resection	6	348.75	8
R913	Axillary or inguinal nodes – radical resection	4	262.50	6
R914	– limited resection	4	142.50	4
Z405	Biopsy (I.O.P.) – **anterior** cervical, axillary, inguinal	4	45.00	4
Z406	– scalene, **posterior cervical**	4	90.00	4
Z578	– multiple para-aortic lymph nodes	6	53.60	6
Z407	– percutaneous retro peritoneal – one group	4	62.25	4
Z409	– two or more groups	4	93.75	4
R916	Re-exploration of vascular graft and closure of lymph fistula in groin	4	142.50	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code **ORAL CAVITY AND PHARYNX**–to include nasopharynx, oropharynx, hypopharynx except where otherwise specified

Code		Assistant	Surgeon	Anæsthetist
	Incision			
Z506	Drainage of **oral** abscess, **or hematoma** (I.O.P.)		$ 37.50	4
Z510	Drainage of pharyngeal abscess **or hematoma (I.O.P.)**		67.50	5
Z524	Drainage of **hematoma** or deep neck abscess (external approach) (I.O.P.)	3	112.50	4
Z501	Biopsy (I.O.P.)		26.25	
Z537	–involving general anæsthetic		56.25	4
	Tongue tie, release of (I.O.P.)			
Z111	**–simple**		11.25	
Z112	**–complex or requiring** general anæsthetic		37.50	4
S031	Palatal fenestration		112.50	4
	Excision			
Z502	Excision of lesion (I.O.P.)–less than 2 cms	3	52.50	4
S003	–2 to 4 cms	4	157.50	6
S006	–over 4 cms	4	262.50	6
S004	Excision of ranula	3	112.50	4
S005	Composite resection of **lesion of oral cavity and/or oropharnyx with partial resection of mandible**	10	450.00	12
E705	–with ipsilateral neck dissection, add		225.00	
S007	**Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla**	**10**	**600.00**	**12**
E705	**–with ipsilateral neck dissection, add**		**225.00**	
S050	Cryotherapy for treatment of pre-malignant or malignant lesions of oral cavity of sinuses–minor		63.75	4
S052	–intermediate		112.50	4
S054	–major		187.50	6
S018	Glossectomy–partial	6	135.00	8
S019	–complete	6	206.25	8
Z109	Wedge excision of lesion (I.O.P.)		45.00	4
S020	Glossoplasty	4	101.25	4
S023	Extraction of tooth (complete care)–single		15.00	4
E700	–each additional tooth		9.40	
S028	Dentigerous cyst	4	48.75	4
S900	Basic units for anæsthesia with any unlisted dental surgical procedure performed by a dental or oral surgeon (see 37(k) on page xi)			I.C.
S021	Repair of extensive laceration	4	I.C.	I.C.
	–for minor lacerations, see Skin			
Z509	Uvulectomy–partial or complete		18.00	4
S034	Cleft palate repair	6	270.00	8
S035	Removal of sutures under general anæsthesia		22.50	4
S032	Bone graft to palate	6	255.00	8
S030	Closure of fistula–anterior alveolar	4	120.00	4
S033	–palate	6	206.25	6
S069	Pharyngoplasty	8	266.25	8
S002	Excision of parapharyngeal space lesions (with mobilization of parotid gland	4	450.00	8
E705	**–with ipsilateral neck dissection, add**		**225.00**	
S067	**Partial** pharyngectomy–trans-hyoid or lateral	8	450.00	11
S068	Pharyngo-laryngectomy	8	600.00	14
E882	**–with hemithyroidectomy, add**		**129.40**	
E883	**–with subtotal thyroidectomy, add**		**195.00**	
E884	**–with total thyroidectomy, add**		**273.75**	
S058	Branchial– **cleft lesion**	4	225.00	4
S059	**Branchial–cleft lesion–repeat procedure**	4	300.00	4
S061	Thyroglossal duct remnant	4	225.00	4
S062	–repeat procedure	4	300.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM—Cont'd.

Code	**ORAL CAVITY AND PHARNYX**—Cont'd.	Assistant	Surgeon	Anæsthetist
S063	Tonsillectomy		$ 108.75	4
	Tonsillectomy and Adenoidectomy—same as Tonsillectomy			
S065	Adenoidectomy		58.10	4
S066	Secondary suture or cauterization **24** hours following T and A or by a surgeon other than the operation surgeon anytime post-operatively—when hæmorrhage occurs after initial procedure and is treated surgically		37.50	5
	SALIVARY GLANDS AND DUCTS			
	Incision			
Z500	Sialolithotomy (I.O.P.)		22.50	
Z521	—involving general anæsthetic	3	75.00	4
	Excision			
S042	Submandibular gland	4	187.50	4
S043	Parotid gland—total (with preservation of facial nerve)	6	495.00	8
S044	—total (without preservation of facial nerve)	6	371.25	8
S045	—subtotal (with preservation of facial nerve)	6	423.75	7
S047	—repeat subtotal (with preservation of facial nerve)	6	495.00	7
S046	—subtotal (without preservation of facial nerve)	6	333.75	6
Z522	Excision small tumour (I.O.P.)	3	37.50	4
	Reconstruction			
S049	Plastic repair of duct	4	150.00	4
Z511	Dilation and/or probing of duct (I.O.P.)		22.50	4
S057	Submandibular duct relocation	6	266.25	6
	LIPS			
	Incision			
Z503	Biopsy (I.O.P.)		26.25	4
	Excision			
S011	Wedge resection of lip—vermillion	3	52.50	4
S010	Wedge resection of lip with plastic repair	3	176.25	4
Z504	Excision of lesion (I.O.P.)	3	45.00	4
S012	Lip shave—vermilionectomy	3	150.00	4
	Reconstruction			
S013	**Cleft** lip—unilateral	6	266.25	8
S014	Reconstruction with lip switch flap	6	322.50	8
S015	Complex reconstruction or revision of previous repair and excision		I.C.	I.C.
	OESOPHAGUS			
	For procedures on the Oesophagus, the following basic units for assistants and anæsthetists will apply except if a basic fee is listed:			
S073	Cervical approach	6		7
S074	Thoracic approach	10		13
S075	Abdominal approach	7		8
	Endoscopies (I.O.P.)			
Z515	Oesophagoscopy, with or without biopsy		52.50	4
Z516	—with removal of foreign body		86.25	4
Z517	Oesophagoscopy with injection of varices—initial		93.75	4
Z518	—subsequent		67.50	4
Z519	Oesophagoscopy with dilation		101.25	4
Z520	Oesophago-bronchoscopy with or without biopsy		97.50	6
Z567	Subsequent procedure (within three months following previous endoscopic procedure)		56.25	6
Z399	Oesophagoscopy-gastroscopy with or without duodenoscopy —elective		78.75	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM—Cont'd.

Code	**OESOPHAGUS**—Cont'd.	Assistant	Surgeon	Anæsthetist
Z400	—for active bleeding		$ 86.25	4
E701	—with laser coagulation, or diathermy add		23.60	
E698	—with pneumatic dilation, add		75.00	
Z568	Subsequent procedure (within three months following previous endoscopic procedure)		52.50	4
E702	—with multiple (3 or more) biopsies of specific lesion, add		11.25	
E703	—with snare polypectomy, add		37.50	
E799	—each additional polyp, add — (to a maximum of 2 additional polyps)		18.75	
	Incision			
	Oesophagostomy			
S084	Cervical—other than neonatal		150.00	
S085	—neonatal		225.00	
	Intrathoracic œsophagus tube			
S082	—via laparotomy		303.75	6
S083	—via œsophagoscope (includes Z515)		225.00	6
S081	Transœsophageal division of œsophageal varices		390.00	
S080	Oesophageal-gastric devascularization (including splenectomy and œsophageal division/anastomosis		645.00	
	Excision			
S087	Intrathoracic diverticulum		360.00	
S088	Crico pharyngeal myotomy		288.75	
E699	—with diverticulum excision, add		27.40	
S089	Partial œsophageal resection and reconstruction (including intestinal transposition)		765.00	17
S090	Total thoracic œsophageal resection		645.00	13
E730	—with reconstruction, add		390.00	4
S093	**Enucleation of benign œsphageal tumour**		**420.00**	
	Repair			
S161	Oesophageal myotomy, partial (below aortic arch)		420.00	
E758	—with œsophageal hiatus hernia repair, add		157.50	
E699	—with diverticulum excision, add		27.40	
S100	Total thoracic œsophageal myotomy when sole procedure performed		532.50	
E758	—with œsophageal hiatus hernia repair, add		157.50	
S091	Oesophageal hiatus hernia—abdominal or transthoracic approach with fundal plication		397.50	
S092	Recurrent œsophageal hiatus hernia		510.00	
E744	—with gastroplasty, add to either S091 or S092		82.50	
E742	When S091 or S092 with or without gastroplasty is done in conjunction with cholecystectomy, and/or vagotomy with or without drainage procedures, add E742 (to S091 or S092 with or without E744) for each additional procedure performed. For any other combination of surgical procedures with œsophageal hiatus hernia repair (with the exception of S161 and S100), use surgical rule (paragraph 3 on page 55)		157.50	
S095	Oesophageal stricture (Thal)—may include œsophageal hiatus hernia repair with or without gastroplasty		461.25	
S096	Ruptured œsophagus, suture and drainage		360.00	
S097	Oesophago-gastrostomyfor by-pass (when sole procedure performed)		382.50	
S098	Oesophageal bypass, abdomen to neck—with stomach		622.50	
S099	—with colon or jejunum		855.00	
	Suture			
S102	Closure of œsophago—tracheal fistula (includes œsophageal reconstruction and lengthening if necessary)		442.50	
	Dilation of Oesophagus (I.O.P.)—when sole procedure performed			
Z529	Passive (bougie)—initial session		29.25	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM—Cont'd.

Code	OESOPHAGUS—Cont'd.	Assistant	Surgeon	Anæsthetist
Z530	—repeat session (within three months following previous dilation)		$ 19.50	
Z525	Pneumatic		78.75	
Z523	With rigid dilators guided over a string or wire		39.00	
Z531	Repeat dilations during the same admission		19.50	
	STOMACH			
	Endoscopies (I.O.P.)			
Z527	Gastroscopy (with or without biopsy or photography)		67.50	4
Z547	Gastroscopy with removal of foreign body		71.25	4
Z528	Subsequent (within three months following previous gastroscopy)		45.00	4
	Incision			
S116	Gastrotomy—with removal of tumour or foreign body	6	213.75	7
E731	—with suture of bleeding peptic ulcer, add		58.50	2
S117	Pyloromyotomy (Ramstedt's)	5	217.50	10
S118	Gastrostomy	6	172.50	7
E697	—with repair of Mallory Weis laceration, add		101.25	
E707	—when done with another intra-abdominal procedure		45.00	
	Excision			
Z526	Biopsy—(Incisional) by gastrotomy (I.O.P.)		52.50	
Z533	—by intubation (I.O.P.)		26.25	
	Gastrectomy			
S122	Wedge resection for ulcer	7	247.50	7
E708	—with vagotomy, add		58.50	
E713	—after previous partial gastrectomy, add		97.50	
S123	Partial or subtotal —distal	7	450.00	8
S125	—proximal	7	491.25	8
E731	—with suture of bleeding peptic ulcer, add		58.50	2
E708	—with vagotomy, add		58.50	
E709	—with cholecystectomy, add		75.00	
E711	—after previous gastro-enterostomy, add		75.00	
E706	—with choledochotomy, add		86.25	
E712	—after previous vagotomy and pyloroplasty, add		75.00	
E713	—after previous partial gastrectomy, add		97.50	
S128	Total gastrectomy, with or without splenectomy	7	675.00	9
E709	—with cholecystectomy, add		75.00	
E706	—with choledochotomy, add		86.25	
E713	**—after previous partial gastrectomy, add**		**97.50**	
S129	Conversion of previous gastrectomy to Roux-en-y	7	498.75	9
S131	Vagotomy—truncal or selective	7	262.50	7
S124	—highly selective (as sole procedure without pyloroplasty or gastroenterostomy)	7	345.00	7
S121	Transabdominal vagotomy after previous vagotomy	7	296.25	8
S120	Gastric bypass or partition, for morbid obesity	7	438.75	10
	Repair			
S132	Pyloroplasty	7	247.50	7
S133	Pyloroplasty and vagotomy	7	375.00	7
E731	—with suture of bleeding peptic ulcer, add		58.50	2
S137	Pyloroplasty or gastroenterostomy plus vagotomy and cholecystectomy	7	547.50	8
E721	—with choledochotomy, add		86.25	
S134	Gastroduodenostomy or gastrojejunostomy	7	247.50	7
E716	—either of above plus vagotomy, add		120.00	
E711	—after previous gastroenterostomy, add		75.00	
E721	—with choledochotomy, add		86.25	1

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM—Cont'd.

Code	**STOMACH**—Cont'd.	Assistant	Surgeon	Anæsthetist
	Suture			
S138	Closure of gastrostomy or other external fistula of stomach	5	$ 210.00	6
S139	Gastrorrhapy (for perforated ulcer or wound)	6	217.50	7
S140	Closure of gastrocolic fistula	7	408.75	7
	Introduction			
Z534	Gastric Cooling (I.O.P.)—ice water lavage of stomach		20.60	
Z532	Gastric Cooling (I.O.P.)—œsophagogastric balloon, with alcohol coolant continuously recirculated		68.60	4
	INTESTINES (EXCEPT RECTUM)			
	Endoscopy (I.O.P.)			
Z560	Duodenoscopy (not chargeable if Z399 and/or Z400 performed on same patient within 3 months)		67.50	4
Z749	Subsequent procedure (within three months following previous endoscopic procedure)		52.50	4
Z561	—with cannulation of pancreatic and/or common bile duct		150.00	4
E666	**—with biliary tract manometry, add**		**37.50**	
Z579	**—with re-cannulation of pancreatic and/or common bile duct (within three months of previous cannulation)**		**127.50**	**4**
Z512	**Endoscopy of ileostomy or colostomy, or reduction of obstructed Koch ileostomy**		**26.25**	**4**
Z514	**—with biopsy**		**31.50**	**4**
Z580	**Endoscopy (using 60 cm. flexible endoscope)**		**40.90**	**4**
E665	**—when Z580 is rendered in private office, add**		**12.60**	
Z555	Endoscopy—of sigmoid to descending colon		40.90	4
E740	—to splenic flexure, add		45.00	
E741	—to hepatic flexure, add		23.25	
E747	—to caecum, add		23.25	
E717	—if biopsy and/or coagulation of angiodysplastic lesion(s) (one or more), add		19.50	
E749	—when Z555 rendered in private office, add		12.60	
Z570	Fulguration of polyp through colonoscope		33.60	4
E719	—each additional polyp, add—(maximum of 4 additional polyps)		16.80	
Z571	Excision of polyp through colonoscope		108.75	4
E720	—each additional polyp, add—(maximum of 2 additional polyps)		54.40	
	Incision			
	Enterotomy			
S149	Ileostomy	6	262.50	7
S150	Small intestine—including excision of polypi or biopsy	6	262.50	7
S151	Insertion of feeding enterostomy	6	210.00	7
E737	—when done with another intra-abdominal procedure, add		52.50	
S154	Large intestine—including excision of polypi	6	262.50	7
S155	Colonoscopy with laparotomy	6	247.50	7
S156	Exteriorization of intestine (Mickulicz)	6	247.50	6
S157	Colostomy	6	262.50	6
S158	Cæcostomy	6	195.00	6
S160	Entero-enterostomy	6	262.50	7
	Excision			
S162	Local excision of lesion of intestine	6	262.50	7
Z750	Resection of exteriorized intestine (I.O.P.)	6	52.50	6
	Resection with anastomosis			
	Small intestine			
S164	duodenum	6	390.00	7
S165	other	6	367.50	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM–Cont'd.

Code	INTESTINES (EXCEPT RECTUM)–Cont'd.	Assistant	Surgeon	Anæsthetist
S166	Small and large intestine terminal ileum, cæcum and ascending colon	7	$435.00	7
S167	Large intestine–any portion	7	435.00	7
E714	Repair of entero-cutaneous fistula in conjunction with bowel resection, add		48.75	
S168	Ileostomy, subtotal colectomy	7	592.50	7
S169	Total colectomy with ileo-rectal anastomosis	9	693.75	9
S171	Left hemicolectomy with anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection and mobilization of splenic flexure)	7	592.50	8
S172	Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy	9	1,230.00	10
S170	Ileostomy plus total colectomy plus abdomino-perineal resection	9	817.50	10
S173	2-Surgeon team–abdominal	9	693.75	10
S174	–perineal		202.50	
E738	–with continent ileostomy, add to either S168, S169, S170, S173 or S174		273.75	
E718	Bowel resection following previous resection with anastomosis, or following S217, S213, S214 or S215, add		101.25	
	E718 is not to be added to S218, S181, S182, S185, S191, S192 or S193			
S188	Bowel resection without anastomosis (colostomy and mucous fistula)	6	386.25	6
S189	Intestinal bypass for morbid obesity	7	427.50	10
	Intestinal Obstruction – one stage (if staged procedure, refer to preamble on page 55 (para. 3)).			
S175	–without resection	6	326.25	6
S176	–with entero-enterostomy	6	408.75	7
S177	–with resection	6	483.75	7
S180	–with enterotomy	6	367.50	7
S178	Intestinal atresia (newborn)	6	483.75	7
S179	Meconium ileus	6	483.75	7
	Repair			
S181	Revision of ileostomy or colostomy– skin level	5	78.75	5
S182	–full thickness	6	247.50	6
S192	Simple revision of continent ileostomy pouch	6	247.50	6
S191	Complete reconstruction of continent ileostomy to include valve repair	6	675.00	7
S193	Revision of standard ileostomy into continent ileostomy pouch	6	543.75	7
S183	Cæcopexy or sigmoidopexy when sole procedure performed	5	165.00	6
	Suture			
S184	Suture of intestine	6	221.25	6
E721	with choledochotomy, add		86.25	1
S185	Closure of colostomy or enterostomy –with or without resection and/or anastomosis	6	262.50	7
S187	Plication of small intestine for adhesions	6	375.00	7
	Manipulation (I.O.P.)			
Z538	Reduction of prolapse		18.00	4
Z539	Dilation of gastrostomy, enterostomy, colostomy, etc.		18.00	4
Z540	Intubation of small intestine (therapeutic or diagnostic) –with or without fluoroscopy		45.40	
E732	–with biopsy, add		20.60	

MECKEL'S DIVERTICULUM

Excision

Code	Procedure	Assistant	Surgeon	Anæsthetist
S194	Meckel's diverticulum	5	213.75	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM--Cont'd.

Code	**MECKEL'S DIVERTICULUM**–Cont'd.	Assistant	Surgeon	Anæsthetist
S159	–with small bowel resection	6	$ 262.50	7
	MESENTERY			
	Excision			
S195	Local excision of lesion	5	180.00	6
S199	Resection of mesentery	5	213.75	6
	APPENDIX			
	Incision			
S204	Drainage of abscess	5	168.75	6
	Excision			
S205	Appendectomy	5	180.00	6
S206	–with gross perforation and peritonitis	5	258.75	6
	RECTUM			
	Endoscopy			
Z535	Sigmoidscopy (with rigid scope) with or without anoscopy (I.O.P.)–**not to be billed with Z555 or Z580**		26.25	4
Z536	–with biopsy		31.50	4
Z592	–with decompression of volvulus		35.25	4
E746	–when Z535, Z536 or Z592 rendered in private office, add		4.10	
	Incision			
	Proctotomy			
S210	–with exploration	4	75.00	4
S211	–with decompression (imperforate anus)	4	75.00	4
S212	–with drainage (perirectal abscess)	4	75.00	4
	Excision			
	Proctectomy			
S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	8	551.25	8
S214	Abdomino-perineal resection or pull through	8	663.75	10
	Two surgeon team			
S215	abdominal surgeon	8	551.25	10
S216	perineal surgeon		202.50	
S217	Hartmann procedure	8	450.00	9
S218	Colon reconstruction following Hartmann procedure	8	551.25	8
Z752	Biopsy of rectosigmoid **or above** for Hirschsprung's disease (I.O.P.)	3	58.50	4
E710	–each additional biopsy		20.60	
S222	Presacral or trans-sacral proctotomy and excision of lesion	4	247.50	6
	Electrocoagulation and/or excision of rectal carcinoma (I.O.P.)			
Z572	–initial	3	101.25	4
Z573	–repeat	3	58.50	4
	Polyps or tumours of rectum or sigmoid (max.–2 polyps any size or technique) (I.O.P.)			
Z753	–electrocoagulation–base under 2 cm		17.25	4
Z754	–excision–base under 2 cm	3	58.50	4
Z755	–electrocoagulation or excision–base over 2 cm	3	101.25	4
	Repair			
S223	Anastomosis of rectum	4	345.00	6
S224	Proctostomy	4	210.00	4
	Rectal prolapse			
S225	Excision of mucus membrane	3	168.75	4
S226	Perineal repair, major	4	262.50	4
S227	Abdominal approach	6	393.75	8
S228	Insertion of Thiersh wire	3	135.00	4
	Suture			
S229	Suture of rectum, trauma-external approach	4	168.75	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM–Cont'd.

Code	**RECTUM**–Cont'd.	Assistant	Surgeon	Anæsthetist
	Closure of fistula			
S231	Recto vaginal (any repair)	4	$ 247.50	6
S525	Recto vesical	5	322.50	6
	Manipulation (I.O.P.)			
Z541	Dilation, and/or disimpaction or removal of foreign body under general anaesthetic (when sole procedure performed)		40.90	4
Z756	Fecal disimpaction–no anaesthetic		26.25	
	OPERATIONS ON THE ANUS			
	Preamble:			
	(1) The fees for excision, ligation, injection of hæmorrhoids and treatment of intra or perianal condyloma accuminata include anoscopy.			
	Endoscopy			
Z543	Anoscopy (proctoscopy) (I.O.P.)		4.50	
	Incision			
Z544	Biopsy (I.O.P.)		24.60	4
Z545	Thrombosed hæmorrhoid(s) (I.O.P.)		18.00	4
S241	Sphincterotomy	3	62.25	4
S242	–with excision of fissure	3	116.25	4
	Excision			
S246	Excision of fissure	3	82.50	4
S247	Hæmorrhoidectomy, with or without sigmoidoscopy or repair of fissure and/or sphincterotomy and/or anal dilation	3	165.00	4
Z565	Complete hæmorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation (I.O.P.)		67.50	4
Z546	Barron ligation(s) (I.O.P.) (not to exceed 6 in any one year)		19.50	
Z566	Barron ligation(s) plus cryotherapy (I.O.P.) (not to exceed 6 in any one year)		24.60	
S249	Local excision for malignancy	3	108.75	4
Z757	Excision of benign anal lesion(s) (I.O.P.)	3	28.90	4
S251	Fistula-in-ano	3	165.00	4
	Introduction			
Z575	Hæmorrhoid injections (I.O.P.) (Maximum 6 in any one year)		19.50	
Z576	Injections for anal fissure (I.O.P.)		25.50	4
	Repair			
S253	Low imperforate anus repair	7	318.75	7
S260	High imperforate anus repair (supra-levator)	7	663.75	7
S256	Excision of scar, for stenosis	3	93.75	4
S257	Anoplasty, for stenosis	4	210.00	4
S258	Repair of anal sphincter	4	210.00	4
S259	Repair of anal sphincter and ano-rectal ring	4	255.00	4
	Destruction (I.O.P.)			
Z548	Cauterization of fissure		24.60	4
Z549	Fulguration of condylomata–local anæsthetic		22.50	
Z758	–general anæsthetic	3	52.50	4
	Manipulation			
Z550	Dilation of anal sphincter (I.O.P.)		8.25	4
S248	Peter Lord procedure		33.75	4
	LIVER			
	Incision			
Z554	Biopsy, incisional (I.O.P.)		50.60	
Z551	Biopsy, needle (I.O.P.)		48.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM—Cont'd.

Code	**LIVER**—Cont'd.	Assistant	Surgeon	Anæsthetist
S268	**Insertion of implantable pump for continuous liver perfusion**	**7**	**$ 427.50**	**7**
	Excision			
	Hepatectomy			
S269	Local excision of lesion	7	247.50	7
S275	Partial lobectomy	8	416.25	8
S270	Left lateral segmental excision (through falciform ligament)	12	645.00	12
S267	Complete left or right lobectomy	12	937.50	12
S271	Extended right lobectomy, through falciform ligament	12	937.50	12
S272	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	6	262.50	6
S274	**Liver transplant—donor**	**6**	**525.00**	**8**
S294	**—recipient**	**20**	**1500.00**	**30**
	Note: For claims purposes, liver lobectomy includes cholecystectomy			
	Repair			
S273	Marsupialization and/or decompression of cyst(s) or abscess(es)	7	247.50	7
E715	—more than three cysts or abscesses, add		52.50	
	BILIARY TRACT—no extra fee for cholangiogram during abdominal surgery			
	Endoscopy (I.O.P.)—to include examination of stomach and duodenum i.e. not to be claimed with Z561			
Z558	Manipulation and/or removal of common bile duct stones with or without sphincterotomy		213.75	5
Z559	Subsequent procedure (within three months following previous endoscopic procedure)		97.50	5
	Insertion of endobiliary prosthesis			
Z556	—first one		58.50	
Z557	—each additional (max. of 3)		31.10	
Z593	Nasobiliary catheter insertion		39.00	
	Incision			
S233	Percutaneous transhepatic catheter drainage of obstructed bile ducts including daily supervison and including percutaneous cholangiogram and catheterization to duodenum if achieved		187.50	
S234	—replacement of catheter in above		37.10	
Z562	Biliary duct calculus manipulation and/or removal via T-tube tract (I.O.P.)—when sole procedure performed		82.50	7
Z542	Intubation of bile duct for obstruction (I.O.P.)		49.10	
S278	Cholecystostomy	7	266.25	7
S276	Choledochotomy **(previous cholecystectomy)**	7	450.00	8
E704	—with choledochoscopy, add		20.25	
S280	Transduodenal sphincterotomy and choledochotomy **(previous cholecystectomy)**	7	622.50	9
S281	Choledochoduodenostomy or choledochoenterostomy or choledochocholedochostomy	7	532.50	9
S282	Cholecystogastrostomy	7	318.75	7
S283	Cholecystoenterostomy	7	318.75	7
E743	—with entero-enterostomy, add (to S281, S283)		108.75	
S285	Intrahepatic choledochoenterostomy (anastomosis above the common **hepatic** duct bifurcation)	9	656.25	12
	Excision			
S287	Cholecystectomy	7	333.75	7
E721	—with choledochotomy, add		86.25	1
E722	—with transduodenal sphincterotomy, add		116.25	1
E728	—with truncal or selective vagotomy, add		120.00	
E729	—with highly selective vagotomy, add		202.50	
S291	Choledochectomy for tumour (for reconstruction, refer to S281)	8	270.00	8
	Repair			
S292	Common duct stricture, dissection and/or resection (for reconstruction, refer to S281)	7	135.00	10

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM—Cont'd.

Code	BILIARY TRACT—Cont'd.	Assistant	Surgeon	Anaesthetist
S293	Biliary duct atresia, infant	8	I.C.	12
	PANCREAS			
Z762	Biopsy, needle (I.O.P.)		$ 58.50	
	Incision			
Z577	Biopsy, incisional (I.O.P.)		86.25	7
S297	Drainage of acute pancreatitis or abscess or marsupialization of cyst	7	247.50	7
	Excision			
	Pancreatectomy			
S298	Complete with splenectomy	9	937.50	13
S300	"Whipple type" procedure	9	937.50	13
S301	Local complete excision of tumour or lesion	8	345.00	8
S309	Distal – body, tail **with or without** splenectomy with or without anastomosis	9	716.25	11
	Repair			
S305	Pancreatic cyst-gastrostomy	7	420.00	8
S306	–duodenostomy	8	420.00	8
S307	–jejunostomy	8	420.00	8
S304	Lateralpancreatoduodenostomy or anastomosis of filleted pancreatic duct to intestine (Puestow)	9	573.75	10

ABDOMEN, PERITONEUM AND OMENTUM

Preamble:

(1) When the laparoscope is used as a means of entrance to perform an intra abdominal procedure, no extra fee for laparoscopy may be claimed.

(2) When an exploratory laparotomy is performed followed by a colostomy through another incision in the abdomen, the colostomy fee should be claimed at 100% and the laparotomy at 85% of the listed fee.

Code	Procedure	Assistant	Surgeon	Anaesthetist
	Paracentesis (I.O.P.)			
Z590	Aspiration for diagnostic sample		18.00	
Z591	Aspiration with therapeutic drainage with or without diagnostic sample		32.80	4
E724	Administration of chemotherapy, or sclerosing agent add		7.90	
Z763	Paracentesis with lavage for diagnosis (I.O.P.)		27.40	4
	Incision			
Z563	Needle biopsy of peritoneum (I.O.P.)		27.40	
Z564	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity (I.O.P.)		52.50	4
S312	Laparotomy, with or without biopsy **or for Hirschsprung's disease** (except biopsies of stomach, liver, pancreas and multiple para-aortic lymph nodes)	6	180.00	6
E745	Insertion of tubes and post-operative continuous peritoneal lavage – when combined with any other abdominal procedure, add		67.50	
S321	Laparotomy for acute trauma	6	247.50	6
E733	–with repair of intestine, single, add		101.25	3
E734	multiple and/or with resection, add		150.00	3
E735	–with splenectomy, (partial or complete) add	2	202.50	3
E736	–with repair of lacerated liver, add	2	135.00	3
E739	–with repair of diaphragm, add	2	86.25	2
E723	–with repair of lacerated spleen, add	2	135.00	3
	Peritoneal abscess			
S313	Subphrenic	7	262.50	7
S314	Abdominal	6	180.00	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM–Cont'd.

Code	ABDOMEN, PERITONEUM AND OMENTUM–Cont'd.	Assistant	Surgeon	Anæsthetist
Z569	Pelvic abscess, incision and drainage–rectal or vaginal approach (I.O.P.)		$ 86.25	4
Z594	Percutaneous abdominal abscess drainage including daily supervision		165.00	
Z595	Replacement of drainage catheter in abdominal abscess		31.10	
Z596	Abscess drainage check		15.60	
Z574	Removal of infected sutures from abdominal wall or re-exploration of wound for bleeding–general anæsthetic (I.O.P.)	4	67.50	4
S311	Umbilical vein intra-abdominal dissection and catheterization	6	165.00	6
S320	Insertion of antabuse into abdominal wall		40.90	
	Insertion of peritoneo–jugular shunt for ascites			
S203	–primary	7	202.50	7
S209	–revision	7	142.50	7
	Excision			
S316	Excision of full thickness abdominal wall tumour and primary closure		I.C.	6
S317	Umbilectomy–plastic	4	78.75	4
S318	Panniculectomy **(includes any necessary diastasis repair)**	6	303.75	6
E748	–with repair of umbilical hernia, add		75.00	
S319	Mesenteric cyst	6	236.25	6
	Endoscopy			
	Peritoneoscopy, culdoscopy or laparoscopy (I.O.P.)			
Z552	–without biopsy	4	78.75	6
Z553	–with biopsy and/or lysis of adhesions and/or removal of foreign body **and/or cautery of endometrial implants**	4	101.25	6
	Repair			
S325	Omentopexy, sole operative procedure	6	168.75	6
	Herniotomy			
S322	Inguinal or femoral–single–**infants**	4	202.50	4
S326	–children	4	180.00	4
S323	– adolescents and adults	4	202.50	4
S328	Unilateral with exploration of other side, infants and children	4	236.25	4
	Strangulated or incarcerated			
S329	–without resection of bowel	4	270.00	5
S330	–with resection of bowel	6	483.75	7
S331	Inguinal and Femoral same side	4	277.50	4
S332	Umbilical–Adolescent or adult	4	217.50	4
S333	–Child (operative)	4	165.00	4
E756	–with resection of strangulated **contents,** add		78.75	2
E757	–without resection of strangulated **contents,** add		39.40	1
S334	Omphalocoele and gastrochisis–one stage–repair	7	262.50	7
	Multiple staged–repair			
S335	(a) Gross method or Silon mesh	7	262.50	7
S336	(b) Second stage repair (completion of abdominal wall closure)	7	262.50	7
	Diaphragmatic, other than œsophageal hernia			
S337	One stage procedure–trans-abdominal	7	360.00	9
S338	–trans-thoracic	9	360.00	13
S339	Second stage and abdominal closure	4	210.00	9
S340	Ventral–post-operative	6	262.50	6
S344	Massive incisional hernia	6	300.00	6
S345	Massive sliding inguinal hernia	6	247.50	6
E725	Recurrent–all types, excepting oesophageal add	2	62.25	2
E726	Repeat recurrent inguinal hernia (more than 2 repairs), add to S322, S323, S326, S329, S330 or S331	2	108.75	2
S342	Epigastric	4	168.75	4
E727	Hydrocoele–extra–applicable to adults only		46.90	
	Suture			
S343	Secondary closure for evisceration–sole operative procedure in abdomen	6	195.00	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

KIDNEY AND PERINEPHRIUM

Preamble:

(1) No additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy.

(2) In a routine surgical approach to the kidney and related procedures, no additional claim should be made for rib resection carried out for access purposes.

(3) When the kidney has been operated on more than one month previously, the fee for the secondary surgery may be increased by 60.00 (E752).

(4) When an adrenalectomy is performed in conjunction with a nephrectomy, and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.

Code	KIDNEY AND PERINEPHRIUM	Assist-ant	Surgeon	Relative Value Units	Anaes-thetist
	Incision				
Z601	Renal biopsy, needle (I.O.P.)		$ 66.00	8.8	4
S401	Drainage of kidney abscess	7	236.25	31.5	7
S402	Drainage of perinephric abscess	7	153.75	20.5	7
S403	Exploration of renal and peri-renal tissues (with or without biopsy or unroofing of cyst)	7	255.00	34.0	7
	Nephrotomy				
S404	–with drainage–nephrostomy–when sole operative procedure	7	255.00	34.0	7
S405	–with removal of calculus	7	345.00	46.0	7
Z600	–change of nephrostomy tube (I.O.P.)		25.50	3.4	
S406	Transection of aberrant renal vessels–sole operative procedure	7	273.75	36.5	7
S407	Pyelotomy–with drainage	7	273.75	36.5	7
S408	–with removal of calculus	7	315.00	42.0	7
S409	–with diversion of urine	7	333.75	44.5	7
	Excision				
S410	Calycectomy with diversion of urine	7	367.50	49.0	7
S411	Partial or hemi-nephrectomy	7	386.25	51.5	7
S423	Partial or hemi-nephrectomy with total ureterectomy	7	420.00	56.0	7
	Nephrectomy				
S412	–ectopic kidney	7	333.75	44.5	7
S413	–lumbar	7	333.75	44.5	7
S415	–transperitoneal	7	375.00	50.0	7
S416	–thoraco-abdominal or radical nephrectomy	9	483.75	64.5	13
S417	–thoraco-abdominal or radical nephrectomy with gland dissection	9	506.25	67.5	13
S418	–thoraco-abdominal or radical nephrectomy with incision and repair of inferior vena cava for removal of tumour thrombus	I.C.	I.C.		I.C.
S424	**Extrophy–plastic closure of bladder with closure of abdominal wall and urethral lengthening with closure of pelvic floor with or without re-implantation of ureters**	**7**	**675.00**	**90.0**	**10**
S420	Nephro-ureterectomy, total, with resection of uretero-vesical junction	7	423.75	56.5	10
S421	Excision of stenosed renal artery with reimplantation or homograft	7	566.25	75.5	15
	Repair				
S422	Pyeloplasty (with or without nephropexy)	7	375.00	50.0	7
E754	–with removal of calculus, add		42.40	5.6	
S426	Nephropexy–when sole operative procedure	7	273.75	36.5	7
S428	Symphysiotomy, for horseshoe kidney with or without nephropexy and associated procedures	7	315.00	42.0	7
	Suture				
S429	Ruptured or lacerated kidney–repair or removal	7	315.00	42.0	7
S430	Removal of staghorn calculus filling renal pelvis and calyces to include x-ray control	7	472.50	63.0	9

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM—Cont'd.

Code	**KIDNEY AND PERINEPHRIUM**—Cont'd.	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Extra Renal Procedures				
S431	Excision of retroperitoneal tumour	7	$273.75	36.5	7
S432	Exploration of retroperitoneal tumour	7	187.50	25.0	7
S433	Sacro-coccygeal teratoma	6	315.00	42.0	6
S400	**Percutaneous nephrostomy with ultrasonic disintegration of renal calculi**	**5**	**262.50**	**35.0**	**6**
	Renal Transplantation Procedures: These fees do not include immunosuppressive therapy which is on a fee for service basis.				
S435	Kidney transplant (surgical team fee)		858.75	114.5	13
S434	Kidney re-transplant (surgical team fee)		1,027.50	137.0	13
S436	Donor nephrectomy—surgical team fee, unilateral or bilateral (to include renal perfusion with hypothermia when rendered by surgeon)	7	333.75	44.5	8
E753	—live donor, add		93.75	12.5	
	For nephrological components, see Diagnostic and Therapeutic Procedures.				
S437	Renal autotransplantation		641.25	85.5	10
	URETER				
	Endoscopic Procedures				
S470	Cystoscopy with manipulation and/or removal of calculus and retrograde pyelogram if required		172.50	23.0	4
	Incision				
S442	Peri-ureteral abscess	6	153.75	20.5	6
	Ureterotomy, abdominal or vaginal exploratory or for drainage				
S443	—upper 2/3	6	187.50	25.0	6
S444	—lower 1/3	6	273.75	36.5	6
	—with removal of calculus				
S445	—upper 2/3	6	270.00	36.0	6
S446	—lower 1/3	6	345.00	46.0	6
	—where ureter has been previously opened				
S447	—upper 2/3	6	315.00	42.0	6
S448	—lower 1/3	6	375.00	50.0	6
	Excision				
S449	Ureterectomy—including uretero-vesical junction	6	315.00	42.0	7
S450	—other	6	236.25	31.5	7
	Repair				
S451	Uretero-vesical anastomosis or re-implantation unilateral	6	315.00	42.0	8
S561	Re-implantation of ureter with extensive tapering	6	472.50	63.0	8
S562	Bifid ureter	6	345.00	46.0	8
S452	Uretero-ileal conduit	6	566.25	75.5	9
S453	Uretero-ileal conduit with total cystectomy	9	896.25	119.5	15
S454	Uretero-ileal conduit with ureterectomy and ileal replacement	6	641.25	85.5	9
	Uretero-intestinal anastomosis or transplant				
S455	—unilateral	6	236.25	31.5	6
S462	—bilateral	6	315.00	42.0	6
S456	—bilateral with cystectomy, one stage	9	705.00	94.0	13
S457	Uretero-ureterostomy	6	397.50	53.0	8
S458	Ureterostomy—cutaneous—unilateral	6	187.50	25.0	6
S463	—with lower third ureterotomy	6	273.75	36.5	6
S459	Uretero-vaginal fistula	6	408.75	54.5	6
S460	Ureterolysis for peri-ureteral fibrosis—unilateral	6	315.00	42.0	6
S461	Ureteroplasty (Hutch)—unilateral	6	236.25	31.5	6
S427	Bladder flap (Baori)—to include re-implantation of ureter	6	360.00	48.0	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM–Cont'd.

Code	URETER–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Suture				
	Spontaneous or traumatic rupture or transection				
S465	–immediate–upper 2/3	6	$ 273.75	36.5	6
S466	–lower 1/3	6	315.00	42.0	6
S467	–late repair–upper 2/3	6	315.00	42.0	6
S468	–lower 1/3	6	345.00	46.0	7

BLADDER

Preamble:

(1) No extra claim should be made for EUA when done at the time of cystoscopy.

(2) Visit fees, as applicable, to be claimed for changing a suprapubic tube.

(3) No extra claim should be made for suprapubic cystotomy when performed in the routine course of gynæcological surgery.

Code		Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
	Endoscopy–Cystoscopy				
	Diagnostic Procedures (I.O.P.)				
Z606	Diagnostic with or without urethroscopy		51.00	6.8	4
Z607	Repeat within 30 days		25.50	3.4	4
Z608	With catheterization of ureters with or without hydrodistension of the bladder, brush biopsy of bladder, collection of ureteral specimens, intravenous function test and retrograde injection of opaque media and calibration and/or dilatation of the ureter–one or both sides		61.90	8.2	4
Z610	With transurethral biopsy, brush biopsy of renal pelvis and/or ureter and/or insertion of ureteral stent		69.40	9.2	4
Z612	With manometry (to include urethral pressure profile if required)		59.60	7.9	4
Z613	With meatotomy or internal urethrotomy		57.40	7.6	4
Z614	With meatotomy and retrograde pyelogram		69.40	9.2	4
Z615	With needle biopsy of prostate		74.25	9.9	4
	Therapeutic Procedures				
S492	With electrocoagulation–tumour(s)		86.25	11.5	4
S493	–Hunner ulcer		86.25	11.5	4
	With excision of tumour or tumours including base and adjacent muscles and electrocoagulation if necessary				
S494	Single tumour 1 to 2 cm. diameter		195.00	26.0	4
S495	Single tumour over 2 cm. diameter		315.00	42.0	4
S496	Multiple tumours		315.00	42.0	4
S497	With resection bladder neck, female		123.75	16.5	4
S498	With resection bladder neck, male		236.25	31.5	5
S499	With electro surgical ureteral meatotomy		123.75	16.5	4
S500	With removal foreign body or calculus		123.75	16.5	4
S501	With removal of ureteric catheter		54.40	7.2	4
E751	With insertion of radioactive substance, in addition to associated procedures		39.75	5.3	
S502	With secondary surgical evacuation of bladder clots and control of hæmorrhage		61.50	8.2	4
	Introduction (I.O.P.)				
	Catheterization; acute retention, change of retention catheter or instillation of medication				
Z602	–office		6.20	.8	
Z603	–home		11.60	1.5	
Z611	–hospital		6.20	.8	
	Incision				
Z605	Aspiration (I.O.P.)		9.00	1.2	
S478	Cystotomy or cystostomy	5	153.75	20.5	5

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM–Cont'd.

Code	**URETER**–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anaes-thetist
S479	Cystotomy or cystostomy and electrocoagulation of tumour	5	$ 236.25	31.5	5
S480	Cystotomy with trochar and cannula and insertion of tube		61.50	8.2	5
E750	–when done in conjunction with another procedure, add		18.75	2.5	
S481	Cystolithotomy–when sole operative procedure	5	187.50	25.0	5
S476	Cutaneous vesicostomy	5	315.00	42.0	5
S477	Reduction cystoplasty (bladder plication)	5	255.00	34.0	5
	Excision				
	Cystectomy				
S482	Partial for tumour or diverticulum (single or multiple)	6	273.75	36.5	6
S483	–with re-implantation of ureter	6	397.50	53.0	7
S490	–with re-implantation of ureters	6	525.00	70.0	7
S484	Complete cystectomy, without transplant	6	472.50	63.0	10
S485	–with uretero-intestinal transplant	8	705.00	94.0	13
S453	–with uretero-ileal conduit	9	896.25	119.5	15
S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	213.75	28.5	6
S487	Excision of urachus, repair of bladder and diversion of urine	6	213.75	28.5	6
S488	Extrophy-excision of bladder and repair of abdominal wall, inclusive of graft	6	153.75	20.5	6
S489	–above including bilateral ureterosigmoidostomy	6	472.50	63.0	6
S491	Plastic repair of extrophy using bladder and including skin flaps	6	472.50	63.0	6
	Repair				
S512	Repair of ruptured bladder	5	236.25	31.5	6
S513	Cystoplasty, using intestine	8	472.50	63.0	9
S518	Plastic repair of bladder neck–child	5	236.25	31.5	5
S519	–adolescent or adult	5	315.00	42.0	5
S520	With diverticulectomy	5	397.50	53.0	7
	Destruction				
S521	Litholapaxy and removal of fragments		153.75	20.5	4
	Suture				
	Closure of fistula				
S522	External, suprapubic	4	187.50	25.0	4
S523	Vesico-vaginal–vaginal approach	4	315.00	42.0	6
S524	–transvesical approach (with or without omental flap)	5	333.75	44.5	6
S525	Vesico-rectal or vesico-sigmoid	5	322.50	43.0	6

URETHRA

Preamble:

(1) No claim should be made for pre-cystoscopy dilatation of the male urethra unless urethral stricture is the primary diagnosis. No claim should be made for dilatation of the female urethra when done at the same time as cystoscopy.

Code		Asist-ant	Surgeon	Relative Value Units	Anaes-thetist
	Endoscopy				
Z617	Urethroscopy–diagnostic (I.O.P.)		25.50	3.4	4
Z618	–with biopsy (I.O.P.)		56.25	7.5	4
S547	Removal of foreign body or calculus		123.75	16.5	4
	Incision				
Z616	Biopsy of urethra (without endoscopy) (I.O.P.)		16.90	2.2	4
S530	Urethrotomy–external	3	153.75	20.5	4
S532	–transurethral (visual)	3	236.25	31.5	4
S531	Urethrostomy	3	153.75	20.5	4
Z604	Meatotomy and plastic repair (I.O.P.)		22.90	3.0	4
S533	For extravasation of urine with multiple drainage	3	153.75	20.5	4

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM–Cont'd.

Code	**URETHRA**–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
S534	–above with external urethrotomy or cystotomy	3	$236.25	31.5	4
Z609	Peri-urethral abscess (I.O.P.)		22.90	3.0	4
	Excision				
S536	Caruncle	3	61.50	8.2	4
S537	Urethral papilloma, single or multiple		61.50	8.2	4
S541	Diverticulectomy–male or female	3	187.50	25.0	4
S542	Posterior urethral valve	4	187.50	25.0	4
S543	Prolapse urethra, excision	3	61.50	8.2	4
S544	Urethrectomy–radical	4	153.75	20.5	4
	Repair				
S548	Urethral sling	4	273.75	36.5	6
S549	Retropubic urethropexy (e.g. Marshall Marchetti) for stress incontinence–primary procedure	4	221.25	29.5	6
S546	–repeat procedure for failed retropubic or vaginal surgery for stress incontinence	4	255.00	34.0	6
S559	Prosthetic procedure for urinary incontinence (e.g. Kauffman, Rosen type etc.)	3	273.75	36.5	5
S560	–where perineum has been previously operated on for incontinence	3	315.00	42.0	5
S563	Removal of perineal incontinence prosthesis	3	103.10	13.7	4
S539	**Insertion of inflatable prosthesis at bladder neck with or without urodynamic control**	**4**	**326.25**	**43.5**	**6**
S540	**Removal of inflatable prothesis at bladder neck**	**3**	**112.50**	**15.0**	**4**
	Urethroplasty				
S545	1st stage–posterior	4	273.75	36.5	6
S550	–anterior	4	206.25	27.5	4
S558	2nd stage	4	168.75	22.5	4
S535	One stage repair (to include skin graft if necessary)	4	273.75	36.5	6
	Suture				
S551	Rupture, anterior urethra (diversion of urine extra)	4	123.75	16.5	4
S552	Posterior urethra–immediate repair	4	315.00	42.0	4
S553	–late repair	4	397.50	53.0	5
	Fistula				
S554	Penile urethra (diversion of urine extra)		66.00	8.8	4
S555	Perineal urethra	4	236.25	31.5	4
S556	Recto-urethral with diversion, colostomy and closure of colostomy	6	397.50	53.0	7
	Destruction				
S557	Urethro-vesicolysis–when sole operative procedure	3	153.75	20.5	4
S564	Transurethral incision or resection of external sphincter (when sole operative procedure)		236.25	31.5	4
	Manipulation (I.O.P.)				
	Dilation of stricture, male				
Z621	–local anæsthetic		7.90		1.0
Z619	–general anæsthetic		37.90	5.0	4
Z622	Dilation of urethra, female		3.90	.5	
Z620	–under general anæsthetic		36.00	4.0	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code	PENIS	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Incision				
	Slit of prepuce (Complete care)				
S567	–newborn		$ 10.50	1.4	
S568	–infant		15.75	2.1	4
S569	–adult or child		21.60	2.9	4
	Excision				
S570	Circumcision–newborn (Complete care)		25.50	3.4	
S573	**–infant, adult or child**	3	65.25	8.7	4
Z702	Biopsy (I.O.P.)		16.90	2.2	4
	Amputation				
S574	Partial	4	123.75	16.5	4
S575	Partial with inguinal glands 1 or 2 stages	4	315.00	42.0	5
S576	Radical with inguinal and femoral glands 1 or 2 stages	6	397.50	53.0	7
Z701	Condylomata (I.O.P.)–local anæsthetic		23.60	3.1	
Z767	–general anæsthetic		56.25	7.5	4
S599	Excision plaque for Peyronies disease	4	150.00	20.0	4
	–where grafting is necessary, add appropriate skin graft fee				
	Repair				
S577	Epispadias	3	236.25	31.5	4
	Hypospadias				
S578	One stage repair	4	236.25	31.5	4
S579	Chordee repair	4	153.75	20.5	4
S580	Plastic reconstruction, urethra	4	236.25	31.5	4
S581	Closure urethro-cutaneous fistula		66.00	8.8	4
S597	Penile prosthesis for impotence	4	221.25	29.5	4
E755	–with inflatable prosthesis, add		39.75	5.3	
S588	Surgical removal of prosthesis	4	80.25	10.7	4
	TESTIS				
	Incision				
Z703	Abscess (I.O.P.)		39.75	5.3	4
Z704	Biopsy (I.O.P.)–single		39.75	5.3	4
Z705	–bilateral		60.00	8.0	4
Z706	–with vasography (see also page 38)		86.25	11.5	4
S589	Orchidectomy–unilateral	3	123.75	16.5	4
S590	Radical removal lymph nodes for testicular tumour	6	600.00	80.0	8
S598	Radical orchidectomy for malignancy–unilateral	3	168.75	22.5	4
	Repair				
S591	Orchidopexy **for undescended testis,** any type, one or two stages to include hernia repair where required	4	236.25	31.5	4
S592	–second stage (Torek) repair		39.75	5.3	4
S593	Exploration for undescended testicle, without orchidopexy	4	187.50	25.0	4
S600	Reduction of torsion of testis or appendix testis **and orchidopexy (one or both sides), if required**	3	168.75	22.5	4
S595	Ruptured testicle	3	123.75	16.5	4
S596	Insertion of testicular prosthesis	3	123.75	16.5	4
	EPIDIDYMIS				
	Incision				
Z707	Abscess (I.O.P.)		39.75	5.3	4
	Excision				
S601	Spermatocœle or spermatic granuloma	3	123.75	16.5	4
S602	Epididymectomy–unilateral	3	123.75	16.5	4
	Repair				
S606	Anastomosis Epididymovasostomy-unilateral	3	123.75	16.5	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM–Cont'd.

Code	TUNICA VAGINALIS	Assist-ant	Surgeon	Relative Value Units	Anaes-thetist
	Incision				
Z708	Hydrocœle aspiration (I.O.P.)		$ 11.70	1.5	
	Excision				
S611	Hydrocœle–unilateral	4	123.75	16.5	4
	SCROTUM				
	Incision				
Z709	Abscess or hæmatocœle (I.O.P.)–local anæsthetic		14.25	1.9	
Z768	–general anæsthetic		39.75	5.3	4
S616	–and exploration–unilateral	3	61.50	8.2	4
	Excision				
S618	Resection of scrotum	3	153.75	20.5	4
	Suture				
S619	Trauma–laceration–depending on extent and complications		I.C		I.C.
	VAS DEFERENS				
	Incision				
Z710	Vasography (I.O.P.)		39.75	5.3	4
	Repair				
S623	**Vasostomy and/or vasoepididymostomy (to include microscopic control if required)**	3	153.75	20.5	4
S625	–including biopsy and vasography	3	187.50	25.0	4
	Suture				
S626	Ligation–uni or bilateral	3	76.90	10.2	4
	SPERMATIC CORD				
	Excision				
S630	Hydrocœle–single	3	123.75	16.5	4
S631	Varicocœle–single	3	123.75	16.5	4
	SEMINAL VESICLES				
	Incision				
Z711	Abscess (I.O.P.)		86.25	11.5	4
	Excision				
S636	Vesiculectomy	3	397.50	53.0	4
	PROSTATE				
	Preamble:				
	(1) A T.U.R. followed within 10 days by a bilateral orchidectomy because of carcinoma of the prostate should be claimed in accordance with paragraph (3) of the Surgical Preamble.				
	Incision				
Z712	Biopsy, needle (I.O.P.)		56.25	7.5	4
Z713	–with drainage abscess (I.O.P.)	3	66.00	8.8	4
S644	Biopsy, perineal, open operation	3	153.75	20.5	4
	Removal of calculus (with or without biopsy)				
S642	–perineal	4	315.00	42.0	4
S643	–retropubic	4	315.00	42.0	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM—Cont'd.

Code	PROSTATE—Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Excision				
	Prostatectomy (not to include investigative cystoscopy) but to include vasectomy when indicated.				
S645	Perineal	6	$ 318.75	42.5	6
S646	Perineal with vesiculectomy	8	483.75	64.5	11
	Suprapubic—(with or without removal of bladder stones)				
S647	—one stage	5	333.75	44.5	6
S648	—two stages—1st stage	5	153.75	20.5	6
S649	—2nd stage	5	187.50	25.0	6
	Retropubic—(with or without removal of bladder stones)				
S650	—simple	5	333.75	44.5	6
S651	—radical	5	513.75	68.5	6
S641	Transpubic total prostatovesiculectomy with pelvic lymph node dissection	8	641.25	85.5	11
S652	Staging pelvic lymphadenectomy for prostatic cancer	7	236.25	31.5	7
	Endoscopy				
S655	Transurethral resection of prostate (no additional fee for cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy when done at the same time)		326.25	43.5	6
S654	Transurethral resection of prostate for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		228.75	30.5	6
S656	Transurethral drainage of abscess		61.50	8.2	5

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Preamble:

(1) In composite operations such as anterior and posterior repair and D&C or anterior and posterior repair and cauterization of cervix and biopsy, the fee shall, unless otherwise mentioned below, be that of the major procedures.

(2) If a D&C is carried out routinely prior to tubal occlusion, no fee (for a D&C) should be claimed. If a D&C is carried out for abnormal bleeding or pregnancy termination in conjunction with tubal occlusion, 85% of S752, S754, S756 or S785 may be claimed in addition to S741. If a D&C is carried out prior to hysterectomy, no fee should be claimed for the D&C.

(3) If culdoscopy is performed as part of a sterilization procedure, no extra fee should be claimed for the culdoscopy.

Code	VULVA AND INTROITUS	Asistant	Surgeon	Relative Value Units	Anæsthetist
	Incision				
S700	Hymenotomy		$ 37.50	5.0	4
	Abscess of vulva, Bartholin or Skene's gland (I.O.P.)–incision and drainage				
Z714	–local anæsthetic		12.75	1.7	
Z715	–general anæsthetic	3	37.50	5.0	4
Z716	Marsupialization of Bartholin's cyst or abscess (I.O.P.)	3	52.50	7.0	4
Z717	Perineotomy (I.O.P.)		12.75	1.7	
	Excision				
	Biopsy(s)–when sole procedure (I.O.P.)				
Z477	–local anaesthetic		13.90	1.7	
Z475	–general anaesthetic	3	37.50	5.0	4
S707	Hymenectomy (with or without perineotomy)		52.50	7.0	4
S706	Cyst of Bartholin's gland	3	93.75	10.0	4
	Condylomata–single or multiple (I.O.P.)				
Z733	Chemical and/or cryosurgery–one or more		8.25	1.1	
	Surgical excision or electrodesiccation				
Z736	–local anæsthetic		20.60	2.5	
Z769	–general anæsthetic		52.50	7.0	4
	Vulvectomy				
S703	Simple	4	187.50	25.0	4
S704	Radical–without gland dissection	6	315.00	42.0	6
E850	–with bilateral inguinal node dissection with or without skin graft, add		142.50	17.0	1
E851	–with bilateral common iliac node dissection with skin graft, add		198.75	25.0	2
	Repair				
S708	Non obstetrical injury to vulva and/or vagina, and/or perineum		I.C.		I.C.
S705	Ligation–of varicose vein of labia		52.50	7.0	4
	VAGINA				
	Endoscopy				
Z478	Vaginoscopy (premenarchal) with or without medication (I.O.P.)		37.50	5.0	4
	Culdoscopy–see page 109				
	Incision				
S712	Culdotomy, drainage or needle puncture		52.50	7.0	4
S713	Culdotomy, incision and exploration	3	93.75	10.0	4
Z728	Incision and drainage of cyst, abscess or hæmatoma		37.50	5.0	4
	Excision				
	Biopsy(s)–when sole procedure (I.O.P.)				
Z722	–local anaesthetic		13.90	1.7	
Z723	–general anaesthetic		37.50	5.0	4
S715	Excision of cyst(s), or benign tumor(s)	3	93.75	12.0	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM–Cont'd.

Code	VAGINA–Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
S742	Colpectomy–e.g., for carcinoma	4	$ 266.25	34.0	6
S702	Excision of congenital vaginal septum	3	93.75	12.0	4
	Repair				
S716	Anterior or posterior repair	4	131.25	16.0	5
S717	Anterior and posterior repair	4	206.25	25.0	5
S718	Anterior and posterior repair and repair of enterocœle and/or vault prolapse	4	255.00	34.0	5
S719	Posterior repair and repair of enterocœle and/or vault prolapse	4	225.00	30.0	5
S72[illegible]	Posterior repair and repair of anal sphincter	4	180.00	24.0	5
S720	Anterior repair (with or without posterior repair) and repair of uterine prolapse (Fothergill or Watkin's interposition)	4	255.00	34.0	5
S721	Anterior, posterior repair with excision of cervical stump	4	255.00	34.0	6
S722	Post hysterectomy vault prolapse with or without enterocœle and with or without anterior and posterior repair–vaginal and/or abdominal approach	4	255.00	34.0	6
S724	Perineorrhaphy **(not to be charged with delivery or other vaginal surgery procedures)**	3	90.00	12.0	4
S725	Colpocleisis (Le Fort or modification)	5	195.00	25.0	5
S726	Construction of artificial vagina	4	I.C.	–	6
	Closure of fistula				
S523	Vesico-vaginal–single surgeon	4	315.00	42.0	6
S734	–two surgeons–vaginal surgeon	4	217.50	29.0	6
S711	–abdominal surgeon		217.50	29.0	
S231	Recto-vaginal (any repair)	4	247.50	33.0	6
S729	Uretero-vaginal	6	382.50	51.0	6
S709	Urethro-vaginal	4	273.75	36.5	4
S549	Retropubic urethropexy (e.g. Marshall Marchetti) for stress in continence–primary procedure	4	221.25	29.5	6
S546	–repeat procedure for failed retropubic or vaginal surgery for stress incontinence	4	255.00	34.0	6
	Retropubic urethropexy–combined abdominal-vaginal procedure for stress incontinence (sling procedure)				
	–following previous failed procedures				
S731	–one surgeon	7	315.00	42.0	7
S732	–two surgeons–vaginal surgeon	7	187.50	25.0	7
S733	–abdominal surgeon		255.00	34.0	
	–following two or more failed procedures				
S748	–one surgeon	7	450.00	60.0	7
S749	–two surgeons–vaginal surgeon	7	255.00	34.0	7
S751	–abdominal surgeon		315.00	42.0	
	Manipulation				
	Examination and/or dilatation **(may include insertion and/or removal of I.U.C.D.)**–when sole procedure				
Z735	General anæsthetic (I.O.P.)		37.50	5.0	4
	CERVIX UTERI				
	Endoscopy (I.O.P.)				
Z731	Initial investigation of abnormal cytology **of vulva and/or vagina or cervix** under colposcopic technique (to include biopsies and curetting)		37.50	5.0	
Z730	Follow up colposcopy		6.40	.8	
	Cauterization (I.O.P.)				
	Chemical		visit fees		
Z732	Cryotherapy		12.75	1.7	
Z724	Electrocautery		6.40	.8	
Z725	Dilatation and cauterization under general anæsthesia		37.50	5.0	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM—Cont'd.

Code	**CERVIX UTERI**—Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Conization				
S744	Knife conization with or without diagnostic curettage (residual stump)	3	$127.50	17.0	4
Z729	Cryoconization, electroconization or CO_2 laser therapy with or without curettage (I.O.P.) – for premalignant lesion (moderate or severe dysplasia or carcinoma in situ) previously proven by biopsy		26.25	3.5	4
	Excision				
Z720	Biopsy—with or without fulgurization (I.O.P.)		12.75	1.7	4
S765	Amputation of cervix	4	131.25	17.0	4
S766	Cervical stump—abdominal	6	187.50	25.0	6
S767	—vaginal	4	187.50	25.0	4
	Note: Excision of cervical polyp(s) under general anæsthesia, use Z720				
	Repair				
S774	Tracheloplasty for incompetent cervix	3	75.00	10.0	4
S750	Trachelorrhaphy (plastic repair of cervix)—not immediately following delivery	3	75.00	10.0	4
	CORPUS UTERI				
	Endoscopy (I.O.P.)				
Z583	Hysteroscopy with or without biopsy		67.50	9.0	
Z585	—with cannulization of tube(s)		78.75	10.5	
	Incision and Excision				
Z719	Endometrial biopsy – suction or curette – endometrial cytology – wash or brush (I.O.P.)		12.75	1.7	
Z581	Office endometrial curettage (I.O.P.)		26.25	3.5	
	Abortion—complete—under 20 weeks		visit fees		
S768	—incomplete—including D & C		67.50	9.0	4
S752	—therapeutic—curettage, intra-amniotic injection (complete)		82.50	11.0	4
S785	—therapeutic—intra-amniotic injection (incomplete) followed by curettage		138.75	18.5	4
S756	—missed abortion		82.50	11.0	4
S770	—hysterotomy	6	180.00	24.0	6
S783	—hysterotomy with tubal interruption	6	202.50	25.0	6
S754	Diagnostic curretage (with or without cauterization, biopsy of cervix, removal of polypi, Rubin's test or hysterosalpingography)		67.50	9.0	4
	Intracavitary application of radium or sealed sources including D&C carried out at same time as application (to include consultation fee)				
S753	—first application		135.00	18.0	4
S755	—repeat application		67.50	9.0	4
S764	Myomectomy	6	255.00	34.0	6
	Hysterectomy (with or without adnexa)				
S757	Total or subtotal—abdominal or vaginal	6	315.00	42.0	6
S758	—with anterior and posterior vaginal repair including enterocœle and/or vault prolapse	6	450.00	60.0	6
S759	—with anterior or posterior vaginal repair including enterocœle and/or vault prolapse	6	382.50	51.0	6
S710	—with omentectomy for malignancy	6	382.50	51.0	6
S769	Radical (Schauta)—vaginal	8	450.00	60.0	8
S763	Radical (Wertheim's)	8	502.50	67.0	8
	Repair				
S771	Hysteropexy (uterine suspension)	6	187.50	25.0	6
S772	—with anterior and posterior vaginal repair	6	255.00	34.0	6
S773	—with anterior or posterior vaginal repair	6	225.00	30.0	6
	Hysteroplasty				
S779	Excision of septum	6	255.00	34.0	6

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM–Cont'd.

Code	CORPUS UTERI–Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
S775	Unification of double uterus (Strassman)	4	$ 315.00	42.0	4
S777	Uterine inversion, operative	4	255.00	34.0	6
S778	Presacral neurectomy (with or without ovarian neurectomy)	6	255.00	34.0	6
	FALLOPIAN TUBE				
	Excision, Suture or Repair				
S784	Ectopic pregnancy (surgical management)	6	232.50	31.0	6
E852	–with tuboplasty, add		22.50	3.0	
S738	Salpingectomy and salpingo-oophorectomy (uni or bilateral)	6	232.50	31.0	6
S741	Tubal occlusion/interruption/removal by any method or approach for the purpose of sterilization	6	127.50	17.0	6
	Tubal plastic operation with or without operating microscope				
S735	Fimbriolysis–unilateral or bilateral	6	180.00	24.0	6
S736	Salpingostomy–unilateral or bilateral	6	217.50	29.0	6
S739	Fimbriolysis and salpingostomy – unilateral or bilateral	6	262.50	34.0	6
S737	Hysterosalpingostomy (anastomosis of tubes to uterus)	6	352.50	47.0	6
S740	Resection of portion of tubes and re-anastomosis	6	352.50	47.0	6
	Repair of extensive tubal and peritubal disease for infertility using operating microscope–not to be charged for reconstruction following previous sterilization procedure				
S743	–unilateral	8	390.00	52.0	8
S728	–bilateral	8	468.75	62.5	8
	OVARY				
	Excision (unilateral or bilateral)				
S780	Biopsy of ovaries by laparotomy	5	180.00	24.0	6
S781	Wedge resection of ovaries (e.g. Stein-Leventhal)	5	187.50	25.0	6
S745	Oophorectomy	6	217.50	29.0	6
S782	Oophorectomy with total omentectomy	6	255.00	34.0	6
S746	Oophorocystectomy	6	217.50	29.0	6
S747	Para ovarian cystectomy	6	217.50	29.0	6
S714	Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy	6	315.00	42.0	6
S727	**Laparotomy with oocyte retrieval**	**4**	**112.50**	**15.0**	**6**

SURGICAL PROCEDURES

OPERATIONS ON THE ENDOCRINE SYSTEM

Code	THYROID GLAND	Assistant	Surgeon	Anæsthetist
	Incision			
Z726	Aspiration, thyroid cyst (I.O.P.)		$ 20.40	
Z727	Percutaneous silicone core needle biopsy, (I.O.P.)		40.90	6
Z771	Aspiration biopsy, thyroid gland or nodule fine needle method (I.O.P.)		20.40	
S786	Abscess		58.50	4
	Excision			
	Biopsy			
S787	Surgical	4	150.00	6
	Thyroidectomy			
S788	Total	6	435.00	8
S789	Subtotal	6	345.00	7
S790	Hemi	6	262.50	7
E880	–parathyroid(s) identification and re-implantation, add		135.00	
E881	–if requiring splitting of sternum, add		60.00	
S791	Excision of solitary nodule	6	217.50	6
	PARATHYROID, THYMUS AND ADRENAL GLANDS			
	Excision			
S795	Exploration and/or removal, parathyroids or parathyroid tumour	6	435.00	8
S796	–if requiring splitting of sternum	10	495.00	13
E880	–parathyroid(s) identification and re-implantation, add		135.00	
S797	Thymectomy	10	442.50	13
S798	Adrenalectomy or exploration–unilateral	10	322.50	10
S799	–bilateral, with or without oophorectomy	10	483.75	11
S800	Adrenalectomy–unilateral for pheochromocytoma	10	420.00	13
Z772	Thymus transplant (I.O.P.)		60.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asistant	Surgeon	Relative Value Units	Anæsthetist
N100	Hypothermia – when employed, basic units for any procedure on nervous system				25
	BRAIN				
	Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour craniotomy plus excision				
N103	–supratentorial	11	$ 780.00	104.0	15
N151	–infratentorial	11	900.00	120.0	15
N152	Craniotomy plus lobectomy	11	817.50	109.0	15
E901	With operating microscope, add		157.50	21.0	
	Meningioma and other tumourous lesions				
	Craniotomy plus excision				
N102	–supratentorial	11	900.00	120.0	15
N153	–infratentorial or basal	11	1,170.00	156.0	15
E901	With operating microscope, add		157.50	21.0	
E902	Lesion greater than 4 cm. diameter, add to N102, N153		273.75	36.5	
E903	Team fee for acoustic neuroma, same approach add		450.00	60.0	
	Intracranial aneurysm repair				
N105	Carotid circulation–**per vessel**	11	960.00	128.0	15
N154	Vertebrobasilar circulation (including aneurysm of vein of Galen)	11	997.50	133.0	15
E901	With operating microscope, add		157.50	21.0	
	Cerebral arteriovenous malformation				
	Craniotomy for obliteration and/or excision				
N106	–supratentorial	11	960.00	128.0	15
N155	–infratentorial	11	997.50	133.0	15
E901	With operating microscope, add		157.50	21.0	
E908	Removal of intracerebral and/or subdural hematoma in conjunction with a ruptured intracranial aneurysm or arteriovenous malformation, add to N105, N106, N154, N155		168.75	22.5	
N107	Extracranial approach to include balloon catheter or embolization techniques	11	626.25	83.5	15
	Extracranial-intracranial microvascular anastomosis				
N218	Superficial temporary artery	11	862.50	115.0	15
N156	Occipital artery	11	900.00	120.0	15
E904	Posterior fossa add		176.25	23.5	
E905	Use of graft (autogenous vessel or synthetic) add		157.50	21.0	
N121	Extracranial-intracranial long venous bypass (from internal carotid in the neck or any of the trunk vessels in the neck or chest to a major intracerebral vessel, i.e. vertebral, internal carotid, middle cerebral)	11	1,252.50	167.0	15
	Carotid-cavernous fistula				
N108	Intracranial obliteration (to include combined cervical and intra-cranial procedure)	11	900.00	120.0	15
N118	Extracranial approach to include balloon catheter or embolization techniques	11	547.50	73.0	15
	Spontaneous intracerebral hæmorrhage				
	Craniotomy plus removal				
N104	–supratentorial	11	645.00	86.0	15
N157	–infratentorial	11	723.75	96.5	15
N120	Burr hole plus drainage	11	352.50	47.0	15
	Intracranial cyst				
	Craniotomy plus evacuation (to include interventriculostomy)				
N158	–supratentorial	11	645.00	86.0	15
N159	–infratentorial	11	742.50	99.0	15
N160	Burr hole plus aspiration	11	292.50	39.0	15
	Brain abscess:				
N117	Craniotomy	11	780.00	104.0	15
N115	Burr hole aspiration	7	390.00	52.0	7
Z818	Subsequent aspiration through existing burr hole within 30 days (I.O.P.)		157.50	21.0	
N113	Craniotomy for brain biopsy (other than for tumour)	11	450.00	60.0	11
N109	Hemispherectomy	11	1,057.50	141.0	15
N110	Lobectomy and/or excision of cortical scar for epilepsy	11	1,170.00	156.0	15

SURGICAL PROCEDURES

OPERATIONS OF THE NERVOUS SYSTEM–Cont'd.

Code	**BRAIN**–Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
N130	Craniotomy plus midline commissurotomy	11	$ 742.50	99.0	15
N128	Repair of encephalocœle	11	585.00	78.0	15
N129	Posterior fossa decompression for Arnold Chiari malformation	11	705.00	94.0	15
N123	Stereotaxis–intracranial (to include ventriculography)	11	585.00	78.0	11
N119	Intracranial implantation of chronic surface electrodes	11	660.00	88.0	11
Z823	Implantation, removal or revision of stimulation pack (I.O.P.)		195.00	26.0	
Z824	Removal of chronic surface or depth electrodes (I.O.P.)		195.00	26.0	
Z813	Burr hole plus needling of brain for biopsy (I.O.P.)	7	217.50	29.0	7
Z806	Ventriculogram, (including burr holes, air or positive contrast) (I.O.P.)		97.50	13.0	
Z802	Ventricular puncture through previous burr hole or fontanelle or puncture and/or aspiration of cisterna magna (I.O.P.)		60.00	8.0	7
Z825	Ventriculoscopy (to include burr hole) (I.O.P.)		232.50	31.0	7
E916	–with biopsy add		97.50	13.0	
E917	–with interventriculostomy add		97.50	13.0	
E918	–with removal of foreign body add		97.50	13.0	
Z819	External ventricular drainage (I.O.P.)	5	157.50	21.0	5
Z820	Insertion of intracranial catheter or transducer for purposes of monitoring (I.O.P.)	5	232.50	31.0	5
Z812	Subsequent revisions or replacements within 30 days (I.O.P.) each	5	157.50	21.0	5
N127	Re-opening of craniotomy for post-operative hæmatoma or infection, or for removal of bone flap	11	330.00	44.0	11
E919	Intracranial duraplasty (greater than 2 cm. diameter) add to any intracranial procedure		176.25	23.5	
E920	Intraoperative electrophysiological monitoring and/or stimulation add to any intracranial procedure		195.00	26.0	
E921	Repeat craniotomy (excluding N127, add to fees for above surgery involving craniotomy)		157.50	21.0	
	Cranio-Cerebral Injuries				
	Non-operative care:		visit fees	–	
	Reduction of skull fracture:				
N139	Simple, depressed	7	273.75	36.5	7
N140	Compound	11	371.25	49.5	11
E912	–with repair of dural laceration add		97.50	13.0	4
	Extracerebral hæmatoma and/or hygroma:				
N143	Drainage by burr hole(s) –unilateral	7	371.25	49.5	7
N144	Drainage and/or removal by craniotomy	11	585.00	78.0	11
	Cerebral injury				
N148	Removal of intracerebral hematoma and/or debridement of traumatized brain (includes management of any skull fracture)	11	645.00	86.0	15
N149	Removal of foreign body from brain	11	645.00	86.0	15
N150	C.S.F. leak–intracranial repair (to include transsphenoidal approach)	11	780.00	104.0	15
N200	Decompressive craniectomy (frontal, sub-temporal)	11	450.00	60.0	11
Z803	Subdural tap (s) (I.O.P.)–unilateral		39.00	5.2	
Z814	Diagnostic burr hole(s) (I.O.P.)–uni or bilateral	7	195.00	26.0	7
	SKULL				
	Repair of skull defect:				
N161	Acrylic or metal cranioplasty	11	412.50	55.0	11
N201	Rib graft cranioplasty (defect less than 7.5 cm)	11	626.25	83.5	15
N202	Replacement of bone flap	11	352.50	47.0	11
N203	Skull tumour, excision	11	273.75	36.5	11
	Craniosynostosis, linear craniectomy:				
N206	–one suture	11	315.00	42.0	11
N207	–multiple sutures	11	412.50	55.0	15
	Morcellation procedure				
N162	–one suture	11	315.00	42.0	11

SURGICAL PROCEDURES

OPERATIONS OF THE NERVOUS SYSTEM–Cont'd.

Code	SKULL–Cont'd.	Asist-ant	Surgeon	Relative Value Units	Anæs-thetist
N163	–multiple sutures	11	$ 412.50	55.0	15
	Lateral canthal advancement				
	Unilateral				
N164	–one surgeon	11	510.00	68.0	15
N165	–two surgeons–major portion	11	315.00	42.0	15
N166	–lesser portion		232.50	31.0	
	Bilateral				
N167	–one surgeon	11	663.75	88.5	15
N168	–two surgeons–major portion	11	412.50	55.0	15
N169	–lesser portion		292.50	39.0	
N208	Craniotomy for craniofacial repair	11	780.00	104.0	15
E922	–with repair of frontonasal encephalocele ... add		157.50	21.0	
	ORBIT				
N211	Craniotomy plus removal of orbital tumour	11	817.50	109.0	15
N212	Craniotomy plus orbital decompression (roof of orbit with or without lateral wall)	11	765.00	102.0	15
N213	Craniotomy for [illegible]compression of optic nerve(s)	11	817.50	109.0	15
E901	With operating microscope, add to N211, N213		157.50	21.0	
	PITUITARY				
N215	Hypophysectomy (other than for removal of tumour)–(any technique)	11	862.50	115.0	15
E901	With operating microscope, add to N215, N171		157.50	21.0	
	Excision of tumour				
N171	Transfrontal	11	900.00	120.0	15
N172	Microscopic transphenoidal for macroadenoma	11	900.00	120.0	15
N173	Microscopic transphenoidal for microadenoma (less than 1 cm.)	11	900.00	120.0	15
	CAROTID AND VERTEBRAL ARTERIES				
N220	Carotid endarterectomy (with or without bypass and/or patch graft)	7	547.50	73.0	10
N223	Vertebral endarterectomy	10	585.00	78.0	10
E923	Intraoperative cerebral blood flow determinations (with carotid endarterectomy, etc.), add to N220, Z808		97.50	13.0	
Z815	Temporal artery; biopsy, ligation or cryosurgery (I.O.P.)		78.75	10.5	4
Z808	Progressive carotid occlusion by Selverstone clamp (I.O.P.)	10	232.50	31.0	10
Z807	Removal of Selverstone clamp (I.O.P.)	10	195.00	26.0	10
	CSF SHUNTING PROCEDURES				
N230	Shunting procedures, all types except those otherwise specified below	11	292.50	39.0	11
N209	Ventriculo-atrial shunt	11	333.75	44.5	11
N210	Lumbo-peritoneal shunt (including laminectomy)	11	292.50	39.0	11
	Revision of CSF shunt–operative				
N245	Proximal end	7	195.00	26.0	7
N175	Distal end (all shunts except ventriculoatrial)	7	195.00	26.0	7
N176	Distal end–ventriculoatrial	7	232.50	31.0	7
Z801	Revision–non-operative		60.00	8.0	
N174	Conversion of shunt (e.g. ventriculoperitoneal to ventriculo-atrial)–includes removal of existing shunt	7	292.50	39.0	7
N246	Removal of shunt–any type	7	135.00	18.0	7
N247	Ventriculo-cisternostomy (Torkildsen)	11	390.00	52.0	11
Z809	Insertion of CSF reservoir (Ommaya) including burr holes (I.O.P.)	11	176.25	23.5	11
N249	Third ventriculostomy	11	450.00	60.0	11
Z821	Injection of diagnostic or therapeutic agent into shunt apparatus (I.O.P.)		39.00	5.2	
	CRANIAL NERVES				
N258	Percutaneous coagulation of gasserian (trigeminal) ganglion or root–unilateral	11	255.00	34.0	11

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM–Cont'd.

Code	CRANIAL NERVES–Cont'd.	Assist-ant	Surgeon	Relative Value Units	Anæs-thetist
N259	V–Decompression or rhizotomy (partial or complete) trigeminal nerve	11	$ 352.50	47.0	11
N265	VII–Differential section facial nerve for hemi-facial spasm (extra-cranial approach)	6	255.00	34.0	6
N266	Anastomosis hypoglossal or accessory to facial nerve	6	412.50	55.0	6
E901	With operating microscope, add to N266, N267		157.50	21.0	
N267	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	11	705.00	94.0	11
N269	XI–Division of nerves to sternomastoid in neck	6	213.75	28.5	6
Z826	Inferior dental neurectomy (I.O.P.)	3	135.00	18.0	4
Z827	Infraorbital or supraorbital neurectomy (I.O.P.)	3	116.25	15.5	4
	PERIPHERAL NERVES				
	Brachial plexus exploration:				
N280	In posterior triangle (not for treatment of cervical rib)	6	330.00	44.0	6
N281	In axilla	6	427.50	57.0	6
N282	In posterior triangle and axilla	6	585.00	78.0	6
N283	Decompression by scalenotomy alone	6	116.25	15.5	6
N284	Decompression by excision of first rib and/or cervical rib to include scalenotomy when required	6	292.50	39.0	6
	Exploration and/or decompression of sciatic nerve				
N177	Subgluteal	6	292.50	39.0	6
N178	In thigh	6	213.75	28.5	6
N179	Subgluteal and in thigh	6	330.00	44.0	6
N290	Decompression median nerve at wrist (carpal tunnel syndrome)	3	116.25	15.5	4
N293	Decompression lateral femoral cutaneous nerve	4	116.25	15.5	4
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding sciatic and carpal tunnel nerve)	4	157.50	21.0	4
N286	Removal of tumour major peripheral nerve	4	232.50	31.0	4
	Suture of major peripheral nerve				
N287	Epineural	4	255.00	34.0	4
N180	Fascicular	4	315.00	42.0	4
N183	Graft of minor nerve e.g. digital	3	112.50	15.0	4
	Graft of major peripheral nerve, with or without lengthening procedure				
N288	Epineural	4	427.50	57.0	4
N181	Fascicular (regardless of the number of strands per gap)	4	487.50	65.0	4
E925	Delayed repair (more than 4 weeks) add		97.50	13.0	
E931	Repeat surgery on peripheral nerve (more than four weeks after original surgery), add		116.25	15.5	
N289	Suture or decompression of small peripheral nerve (digital)	3	112.50	15.0	4
E906	With operating microscope – add to peripheral nerve repair as specified (N286, N287, N180, N285, N288, N181, N289)		78.75	10.5	
N294	Division, obturator nerves	6	135.00	18.0	6
Z828	Biopsy and/or avulsion peripheral nerve (I.O.P)	3	116.25	15.5	4
N295	Morton's neuroma, excision	4	78.75	10.5	4
Z811	Excision of glomus tumour (I.O.P.)		75.00	10.0	4
Z136	Excision of neuroma–single, subcutaneous (I.O.P.)		75.00	10.0	4
N296	Denervation of gastrocnemius	4	131.60	18.0	4
Z816	Implantation of electrode for peripheral nerve stimulation (I.O.P.)	3	176.25	23.5	4
	AUTONOMIC NERVOUS SYSTEM				
	Sympathectomy:–unilateral				
N300	Cervical	6	255.00	34.0	6
N301	Cervicodorsal	10	427.50	57.0	10
N303	–thoracic approach	9	315.00	42.0	13
N304	Lumbar	6	213.75	28.5	6

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM–Cont'd.

Code	SPINAL CORD AND NERVE ROOTS	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Tumours:				
N317	Extradural partial or total removal	8	$ 645.00	86.0	10
	Removal by anterior or anterolateral cervical or thoracic approach				
N314	–one surgeon	9	862.50	115.0	13
M137	–two surgeons–thoracotomy		279.40	–	
N313	–excision	9	742.50	99.0	13
N318	Intradural (extramedullary) partial or total removal	8	817.50	109.0	10
E914	–three segments or more add		116.25	15.5	
	Intramedullary:				
N319	–Biopsy and/or decompression		292.50	39.0	9
N320	–Removal		937.50	125.0	12
E914	–three segments or more add		116.25	15.5	
E901	With operating microscope (applies to intradural or intramedullary tumours) add		157.50	21.0	
	A.-V. malformation of cord				
N321	Excision or operative obliteration; with or without evacuation of haematoma		937.50	125.0	12
E914	–three segments or more add		116.25	15.5	
E901	With operating microscope add		157.50	21.0	
Z800	Myeloscopy (I.O.P.)		157.50	21.0	
	Decompressive Procedures				
	Applicable to all operative procedures for decompression of the spinal cord and/or nerve roots, whether traumatic or non-traumatic, with the exception of tumours and arterio-venous malformations and others separately listed.				
	Posterior Spinal Decompressive Procedures				
R451	Cervical hemilaminectomy for disc disease, with or without foraminotomy	6	431.25	57.5	10
R457	Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	6	315.00	42.0	8
N185	Posterior laminectomy one or two levels, cervical, thoracic, lumbar	6	450.00	60.0	9
N337	Repeat posterior **exploration** or reopening of posterior **exploration,** more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	8	487.50	65.0	10
E565	Multiple levels, to R451, R457 **only** per additional level add		60.00	8.0	
E566	Bilateral, to R451, R457 add		60.00	8.0	
E914	Laminectomy extending over 3 or more laminae, to N185, N337 ... add		116.25	15.5	
E915	Foraminotomy, to R457, N185 per foramen decompressed add		60.00	8.0	
	Anterior, Anterolateral or Posterolateral Spinal Decompressive Procedures				
R447	Simple anterior cervical discectomy	8	273.75	36.5	10
R452	Simple anterior lumbar discectomy	6	390.00	52.0	10
N182	Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level	8	450.00	60.0	10
N186	Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level	9	817.50	109.0	13
	For thoracotomy or laparotomy by separate surgeon use M137 (page 91), S312 (page 108).				
E928	Each additional disc level decompressed, to R447, R452, N182, N186 add		195.00	26.0	
	Fusions				
E929	Anterior cervical interbody fusion by same surgeon, to R447, N182, per disc level add		60.00	8.0	
	Fusion by same surgeon, to any procedure except anterior cervical interbody fusion,				
E567	–one level add		195.00	26.0	
E568	–two or more levels add		255.00	34.0	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	SPINAL CORD AND NERVE ROOTS—Cont'd.	Assistant	Surgeon	Relative Value Units	Anaesthetist
	Fusion by different surgeon:				
R493	—one level		$ 232.50	31.0	
R494	—two or more levels		273.75	36.5	
E574	Repeat fusion, to any fusion, **not to apply to N337,** add		176.25	23.5	
E548	With instrumentation add		116.25	15.5	
	Dural opening and repair:				
E907	Opening of dura (associated with any decompressive procedure) .. add		116.25	15.5	
E926	Spinal duroplasty (applies to any spinal procedure) add		176.25	23.5	
	Other Laminectomies (uni- or bilateral)				
N336	Laminectomy for intradural neurolysis or unusual lesions e.g. diastematomyelia, tethered conus, intramedullary hematoma, etc.	7	585.00	78.0	8
E914	Laminectomy extending over 3 segments or more (applies to tethered conus, diastematomyelia extradural, intradural or intramedullary tumour, AVM, or other decompressive laminectomy, add		116.25	15.5	
E901	With operating microscope add		157.50	21.0	
N323	Re-opening of laminectomy for post-operative hematoma or infection	7	273.75	36.5	8
N192	Re-opening of laminectomy for repair of CSF leak	7	390.00	52.0	8
	Spinal Fractures				
Z236	Skull calibers (I.O.P.)		37.50	5.0	
Z241	Halo traction (I.O.P.)		60.00	8.0	
Z246	Reapplication of Halo traction (I.O.P.)		37.50	5.0	
E562	Counter traction pins or vest – add		78.75	10.5	
F103	Closed reduction	5	138.75	18.5	5
F105	Open reduction, posterior approach	5	232.50	31.0	9
F107	anterior approach	7	273.75	36.5	10
E913	With spinal cord injury, add (when total care by operating surgeon)		116.25	15.5	
E927	With irrigation, includes opening of dura, to fractures when combined with decompressive procedures add		232.50	31.0	
E567	Fusion by same surgeon—one level add		195.00	26.0	
E568	—multiple levels add		255.00	34.0	
E929	—anterior cervical interbody fusion, per level add		60.00	8.0	
R493	Fusion by different surgeon—one level add		232.50	31.0	
R494	—multiple levels add		273.75	36.5	
E924	—anterior cervical interbody fusion, per level add		90.00	12.0	
E548	With instrumentation add		116.25	15.5	
	Syringomyelia				
N193	Posterior fossa craniectomy and plugging of obex (to include decompression of Arnold Chiari malformation if present)		742.50	99.0	15
E919	Intracranial duraplasty (greater than 2 cm. diameter), add to any intracranial procedure		176.25	23.5	
N194	Syringo subarachnoid shunt	8	585.00	78.0	10
N195	Terminal ventriculostomy	8	585.00	78.0	10
N196	Syringopleural/syringoperitoneal shunt	9	682.50	91.0	12
E901	With operating microscope (add to N193-N196)		157.50	21.0	
	Ablative and Stimulation Procedures				
N329	Percutaneous cordotomy or tractotomy	6	292.50	39.0	8
N330	Open myelotomy for lesion (e.g. tractotomy, midline commissurotomy, Bischoff's longitudinal myelotomy, etc.) uni- or bilateral	8	705.00	94.0	10
N341	Medullary spinal trigeminal tractotomy	10	742.50	99.0	15
E901	With operating microscope		157.50	21.0	
N326	Percutaneous diagnostic stimulation of spinal cord	6	255.00	34.0	8
N324	Implantation of spinal cord stimulating electrode by laminectomy	8	412.50	55.0	10

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM—Cont'd.

Code	SPINAL CORD AND NERVE ROOTS—Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
Z822	Implantation or revision of stimulation pack for chronic stimulation (I.O.P.)		$195.00	26.0	5
N332	Removal of stimulation system		157.50	21.0	5
N331	Spinal intradural anterior and/or posterior rhizotomy, unilateral or bilateral, any number of roots	8	468.75	62.5	10
N333	Dorsal root entry zone lesions for pain relief (any number of levels) – includes use of operating microscope	8	742.50	99.0	10
	Percutaneous vertebral facet denervation or intercostal neurectomy (I.O.P.)				
Z810	–one level		60.00	8.0	4
E909	–additional levels (to a maximum of 4 additional levels)–each		19.50	2.6	
	Percutaneous radiofrequency posterior rhizotomy for pain or spasticity				
N340	–one or two roots	6	195.00	26.0	8
E910	–third to sixth root, each		39.00	5.2	
Z817	Lumbar subarachnoid drainage of CSF (chronic)(I.O.P.)		60.00	8.0	
	Meningocele and Meningomyelocele				
N334	Repair of meningocele	7	315.00	42.0	9
	Repair of meningomyelocele				
N335	–one surgeon	7	427.50	57.0	9
N338	–two surgeons–neurosurgeon	7	315.00	42.0	9
N339	–reconstructive surgeon		255.00	34.0	
N197	Repair of lipomeningocele (to include release of tethered spinal cord)	7	607.50	81.0	9
E901	With operating microscope (add to N197, N335 or N338)		157.50	21.0	
N198	Repair of anterior sacral meningocele–posterior approach (to include release of tethered spinal cord)	7	626.25	83.5	9
N199	Repair of intraspinal meningocele (extradural cyst)	7	626.25	83.5	9

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	OPERATIONS ON THE EYE				
Z850	Examination and unlisted minor procedures under general anæsthesia (I.O.P.)		$ 48.00	6.4	4
	EYEBALL				
	Excision				
E102	Enucleation	4	191.25	25.5	4
E103	Evisceration	4	191.25	25.5	4
E108	Enucleation, donor eye, post-mortem (one or both)		95.60	12.7	
	Repair				
E104	Removal of intraocular foreign body	4	272.25	36.3	6
E105	Non-magnetic–posterior segment	4	309.00	41.2	6
	Penetrating wound				
E106	–with prolapse of intraocular tissue	4	191.25	25.5	6
E107	–without prolapse of intraocular tissue	4	154.50	20.6	6
	CORNEA				
	Incision				
Z851	Paracentesis (I.O.P.)		38.25	5.1	4
	Removal embedded foreign body (I.O.P.)				
Z847	–local anæsthetic–one foreign body		19.10	2.5	
Z848	–two or more foreign bodies		I.C.		
Z852	–general anæsthetic		38.25	5.1	4
	Chelation of band keratopathy with EDTA (I.O.P.)				
Z849	local anaesthetic		19.10	2.5	
Z863	–general anaesthetic		38.25	5.1	4
	Excision				
E206	Pterygium–simple (unilateral)		67.50	8.0	4
E205	–with partial keratectomy	4	176.25	23.5	4
E207	–with lamellar graft	4	309.00	41.2	8
E117	Keratectomy	4	176.25	23.5	4
E118	Excision of dermoid–with partial keratectomy		176.25	23.5	4
E119	–with lamellar graft	4	309.00	41.2	8
	Cauterization of ulcer (I.O.P.)				
Z871	–local anæsthetic		19.10	2.5	
Z853	–general anæsthetic		38.25	5.1	4
	Replacement				
	Corneal transplant				
E121	–penetrating	4	405.00	54.0	8
E951	–with artificial prosthesis, add		38.25	5.1	
E122	–lamellar	4	309.00	41.2	8
E123	Division of iris to cornea		117.75	15.7	4
	SCLERA				
	Incision				
E127	Sclerotomy, posterior		95.60	12.7	4
E128	Anterior chamber–open evacuation of clot	4	228.00	30.4	6
	IRIS AND CILIARY BODY				
E131	Laser iridotomy	4	172.50	22.0	4
E134	Laser angle surgery		213.00	28.4	4
E130	Iridectomy–surgical	4	202.50	26.0	4
E132	Glaucoma filtering procedures	4	228.00	30.4	6
E133	Extraocular glaucoma procedures	4	132.40	17.7	4
E135	Ciliary body re-attachment	4	367.50	49.0	8

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES–Cont'd.

Code	CRYSTALLINE LENS	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Incision				
	Needling (discission)				
E137	–primary or subsequent		$117.75	15.7	5
E139	Capsulotomy	4	117.75	15.7	4
	Excision				
	Cataract (to include retrobulbar injection when administered by surgeon)				
E140	–all types of by any procedure	4	309.00	41.2	8
E141	–dislocated lens extraction	4	367.50	49.0	6
E950	–insertion of intraocular lens, extra		95.60	12.7	
E138	Fixation of intraocular lens (McCannell suture procedure)	4	202.50	26.0	6
E143	–excision of secondary membrane with corneal section following cataract extraction	4	191.25	25.5	6
E144	Removal of intraocular lens	4	191.25	25.5	6
E145	Repositioning surgical of dislocated intraocular lens		95.60	12.7	4
E146	Insertion of secondary intraocular lens	4	213.00	28.4	8
	VITREOUS				
E147	Vitreous transplant, implant or anterior vitrectomy	4	191.25	25.5	6
E148	Vitrectomy by infusion suction cutter technique	4	441.00	58.8	8
E149	Vitreous aspiration, posterior with needle for culture and/or injection of medication, with or without cryopexy	4	132.40	17.7	5
	RETINA				
E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure	6	213.75	21.0	6
E152	Scleral resection or buckling procedure – with or without diathermy, photocoagulation or cryopexy, primary or subsequent procedure	6	405.00	54.0	6
E153	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy	6	463.50	61.8	6
E161	Removal of scleral implant		117.75	15.7	4
E154	Photocoagulation (xenon, argon laser, etc.)–one eye		132.40	17.7	6
E155	Cryopexy–extraocular or sub-conjunctival–one eye		132.40	17.7	6
	EXTRAOCULAR MUSCLES				
	Repair				
	Strabismus procedures				
E159	–one or two muscles, one or both eyes	3	191.25	25.5	5
E162	–three or more muscles, one or both eyes	3	228.00	30.4	5
E949	–for adjustable suture, add		38.25	5.1	
E952	Repeat strabismus procedure (more than two previous repairs by different surgeon), add		38.25	5.1	
	ORBIT				
	Incision				
E164	Drainage of abscess		150.00	16.0	6
	Excision				
	Tumour or foreign body				
E166	–anterior route	4	191.25	25.5	6
E167	–posterior exposure	4	345.00	46.0	6
E171	Exenteration, with or without major plastic repair	4	272.25	36.3	6
E172	Biopsy (anterior)		117.75	15.7	4
E168	Biopsy (posterior exposure)		191.25	25.5	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES–Cont'd.

Code	**ORBIT**–Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
E165	Lateral orbitotomy (Kronlein)	3	$ 309.00	41.2	6
E169	Decompression–two walls	4	345.00	46.0	6
E170	–three walls	4	345.00	46.0	6
	Reconstruction				
E160	**Dermis fat graft–immediately following enucleation**		**138.75**	**18.5**	
E163	**–delayed**	**4**	**375.60**	**50.0**	**6**
	Repair–for E173, E174, E175, see pages 75, 76				
	EYELIDS				
	Incision				
	Drainage of abscess (I.O.P.)				
Z854	–local anæsthetic		19.10	2.5	
Z855	–general anæsthetic		48.00	6.4	4
	Excision				
	Chalazion–single or multiple (I.O.P.)				
Z874	–local anæsthetic		19.10	2.5	
Z856	–general anæsthetic		48.00	6.4	4
Z857	Epilation–by hyfrecator, electrolysis (I.O.P.)		19.10	2.5	4
Z858	–by cryopexy		48.00	6.4	4
	Verruca, papilloma, keratosis, etc. (I.O.P.)–see page 57				
	Lid Tumours including Xanthelasma or Unlisted Plastic Procedures–see page 62				
	Suture				
E190	Tarsorrhaphy		81.00	10.8	4
E191	Double adhesion		117.75	15.7	4
	Repair				
E192	Ptosis	4	228.00	30.4	4
E193	–repeat or second repair	4	286.50	38.2	6
E194	Distichiasis–unilateral	4	176.25	23.5	4
E195	Trichiasis, repair by tarsal transplantation	4	176.25	23.5	4
E196	Entropion, other than Zeigler puncture	4	191.25	25.5	4
E945	–repeat by second surgeon, add		38.25	5.1	
E948	–with mucous membrane graft, add		81.00	10.8	
E197	Ectropion, other than Zeigler puncture	4	191.25	25.5	4
E945	–repeat by second surgeon, add		38.25	5.1	
	–with skin graft, see page 60.				
Z860	Zeigler punctures (for entropion/ectropion) (I.O.P.)		19.10	2.5	4
E199	Laceration, full thickness		95.60	12.7	4
E198	–including lid margin		191.25	25.5	4
	Blepharoplasty				
E200	**–excision of skin, with or without partial excision of the orbicularis oculi muscle–one lid**		60.00	8.0	4
E201	**–same as E200 plus removal of orbital fat/and or lid fold reconstruction–one lid**	4	150.00	20.0	4
E211	Lid lengthening procedure	4	132.40	17.7	4
E953	–with scleral graft, add		58.90	7.8	
	CONJUNCTIVA				
	Removal of foreign body		visit fee		
	Excision				
E208	Peritomy (Gunderson conjunctival flap)		81.00	10.8	4
Z861	Biopsy (I.O.P.)		19.10	2.5	4
	Repair				
E210	Excision and repair of conjunctival lesion		58.90	7.8	4
E948	Mucous membrane graft		81.00	10.8	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES–Cont'd.

Code	LACRIMAL TRACT	Assistant	Surgeon	Relative Value Units	Anæsthetist
	Incision				
Z862	Dacryocystotomy–general anæsthetic (I.O.P.)		$ 38.25	5.1	4
Z917	Three "Snip" punctum procedure (I.O.P.)		48.00	6.4	4
	Excision				
E215	Dacryocystectomy	4	191.25	25.5	4
	Repair				
	Lacerated canaliculus				
E216	–immediate repair	4	154.50	20.6	4
E217	–delayed repair	4	249.75	33.3	5
E218	Dacryocystorhinostomy	5	309.00	41.2	5
E954	–with lacrimal bypass procedure (e.g. Lester Jones) or canalicular reconstruction, add		58.90	7.8	
	Lacrimal bypass procedure (e.g. Lester Jones)				
E219	–when sole procedure (both stages)		132.00	17.6	4
E220	Lateral canthal tenodesis		191.25	25.5	5
	Manipulation (I.O.P.)				
Z901	Irrigation of nasolacrimal system–unilateral or bilateral		14.70	2.0	
	Probing and dilation of duct, initial or repeat				
Z902	Local anæsthetic, unilateral		14.70	2.0	
Z864	General anæsthetic–unilateral or bilateral		58.90	7.8	4
Z865	–with insertion of inlying tube or filament		117.75	15.7	4
Z918	Re-insertion of Lester Jones tube		38.25	5.1	

OPERATIONS ON THE EAR

Preamble:

(1) When debridement of ears under microscopy is carried out for access purposes only, no claim should be made for the debridement. If debridement of ears under microscopy is carried out because of pathology, a claim should be made for this service.

EXTERNAL EAR

Code		Surgeon	Anæsthetist
	Endoscopy		
	Removal of foreign body–simple	visit fee	
Z866	–complicated–general anæsthetic (I.O.P.)	37.50	4
E302	–requiring post auricular or endaural incisions	150.00	4
E303	–from middle ear space	150.00	4
Z906	Removal of drainage tube(s)–general anæsthetic (I.O.P.)	26.25	4
Z907	Debridement of mastoid cavities and/or repair of small perforation under microscopy but not for removal of cerumen for "access only" to the tympanic membrane (I.O.P.)	19.50	
Z908	–under general anæsthetic (I.O.P.)–**when sole procedure performed**	37.50	4
	Incision		
Z909	Biopsy, ear canal (I.O.P.)	18.75	
Z846	–general anæsthetic (if sole procedure performed)	37.50	4
E317	**Incision and drainage of extensive hematoma of pinna under general anæsthetic**	**103.50**	4
E305	Limited incision for perichondritis, removal of cartilage and drainage	103.50	4
E306	Radical surgery for perichondritis	213.75	5
	Excision		
Z904	Local excision, polyp–office (I.O.P.)	19.50	
Z905	–hospital (I.O.P.)	37.50	4
E300	Resection of pinna–with primary closure	105.00	4
E301	–with local flap	135.00	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES–Cont'd.

Code	**EXTERNAL EAR**–Cont'd.	Assistant	Surgeon	Relative Value Units	Anæsthetist
E311	Exostosis, simple endomeatal surgery and removal and drilling out of exostosis		$100.50		4
E312	–with multiple removal with necessary grafting		154.50		4
E313	–post auricular approach		213.75		5
Z903	Pre-auricular sinus (I.O.P.)		24.40		
E309	–requiring general anæsthetic		153.75		5
	Repair				
	Congenital defects				
E307	external–minor	5	142.50		5
E308	–major	5	221.25		5
E310	Otoplasty for correction of outstanding ears–unilateral	5	168.75		5
E304	Total ear reconstruction with cartilage graft–(Brent technique)	4	450.00		9
E314	Meatoplasty or canalplasty for congenital malformation	5	150.00		5
E955	–with grafting of canal, add		150.00		1
E956	–with tympanoplasty and/or ossiculoplasty, and/or mastoidectomy, **add**		296.25		2
	MIDDLE EAR				
	Introduction (I.O.P.)				
	Eustachian **cathertization**				
Z910	Unilateral–local anæsthetic		4.50		
Z911	Unilateral or bilateral–general anæsthetic		26.25		4
	Incision (I.O.P.)				
Z912	Myringotomy, to include aspiration when indicated – unilateral		30.90		4
Z914	–with insertion of ventilation tube using operating microscope –unilateral		58.10		4
	Excision				
	Mastoidectomy				
E320	Cortical mastoidectomy	4	232.50		6
E322	Modified or radical mastoidectomy	4	371.25		7
E315	Revision mastoidectomy with revision of middle ear	4	401.25		7
E946	–with mastoid cavity obliteration (E320, E322 or E315), add		75.00		
E959	–with meatoplasty and/or canalplasty, add		75.00		
E960	**–with ossiculoplasty (E320, E322 or E315), add**		**63.00**		
	Repair				
E323	Myringoplasty		154.50		5
E336	Tympanoplasty–Type 1 (myringoplasty with exploration of middle ear)		232.50		7
E337	–with ossiculoplasty		333.75		7
E957	–with mastoidectomy, add		100.50		
E959	–with meatoplasty and/or canalplasty, add		75.00		
E333	Ossiculoplasty	4	300.00		7
E325	Facial nerve decompression	4	525.00		9
E326	Facial nerve **grafting (to include decompression)**	4	675.00		9
E327	Closure of mastoid fistula	4	185.25		4
E328	Tympanotomy		154.50		4
E329	Tympanic neurectomy		273.75		6
E316	Tympanotomy with fistula repair		300.00		6
E324	Tympanotomy with insertion of "permanent" ventilation tube		193.50		4
	INNER EAR				
	Incision				
E332	Labyrinthotomy of labyrinthectomy (including Fick procedure)		405.00		7
	Repair				
E334	Stapes mobilization, unilateral		273.75		6
E335	Stapedectomy with prosthesis		405.00		6
E338	Singular nerve section	4	487.50		9
E339	Endolymphatic shunt or sac decompression	4	450.00		9

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